

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10840

CERTIFICATE OF DEATH

10840

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 8 yrs. 9 mos. 11 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg (?)		d. STREET ADDRESS 8909 Old Bladensburg Rd.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First JOHN	Middle COOK	Lost ALLEN	4. DATE OF DEATH AUGUST 15 1967	Month AUGUST	Day 15	Year 1967	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED Sep.	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-14-08	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George A. Allen				14. MOTHER'S MAIDEN NAME Unk.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-05-0401		17. INFORMANT Records, Springfield State Hospital		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1531 <i>Carcinoma of colon - splenic flexure</i>						INTERVAL BETWEEN ONSET AND DEATH Months			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Schizophrenic reaction, paranoid type						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-31-58 , 19 8-15-67 , 19_____, that (I) (we) last saw the deceased alive on 8-15-67 , 19_____, and that death occurred at 8:30 AM , from causes and on the date stated above.									
22a. SIGNATURE <i>Octavio A. Ruiz</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-15-67			
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-17-67		23c. NAME OF CEMETERY OR CREMATORIAL Newington Baptist		23d. LOCATION (City or Town) Clayton		(County) (State) VA.	
24. FUNERAL DIRECTOR Harry W. Kight		ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR AUG 17 1967		25b. REGISTRAR'S SIGNATURE <i>James J. Kight</i>			

PHOTO BY TROY LEE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G391 8/10/67 phFOR STATE
HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMR Report.
 2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
 3
Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10841

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10841

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster RD #5		c. LENGTH OF STAY IN lb 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster RD #5			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First ROLAND	Middle PETER	Lost BAILE	4. DATE OF DEATH 8 - 3 - 1967	Month 8	Doy 3	Year 1967
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5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 17, 1888	9. AGE (In years last birthday) 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) manager	10b. KIND OF BUSINESS OR INDUSTRY Medford Grocery Co.	11. BIRTHPLACE (State or foreign country) Carroll County	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Jesse Baile	14. MOTHER'S MAIDEN NAME Louise Englart	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	16. SOCIAL SECURITY NO. 218-24-1859A	17. INFORMANT Sterling R. Baile	Address New Windsor, Md.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio's Sclerotic Heart Disease DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) lost.	INTERVAL BETWEEN ONSET AND DEATH Several days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
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ACTUAL SIGNATURE William Speciales	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) William Speciales		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 8/5/67	23c. NAME OF CEMETERY OR CREMATORIAL Meadow Branch Cemetery	23d. LOCATION (City or Town) (County) Westminster RD, Md.
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24. FUNERAL DIRECTOR S.E. Myers, Jr., Westminster, Md.	ADDRESS 135 E. Westminster Carroll	25a. REC'D BY REGISTRAR AUG 7 1967	25b. REGISTRAR'S SIGNATURE Charles Juges
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10842

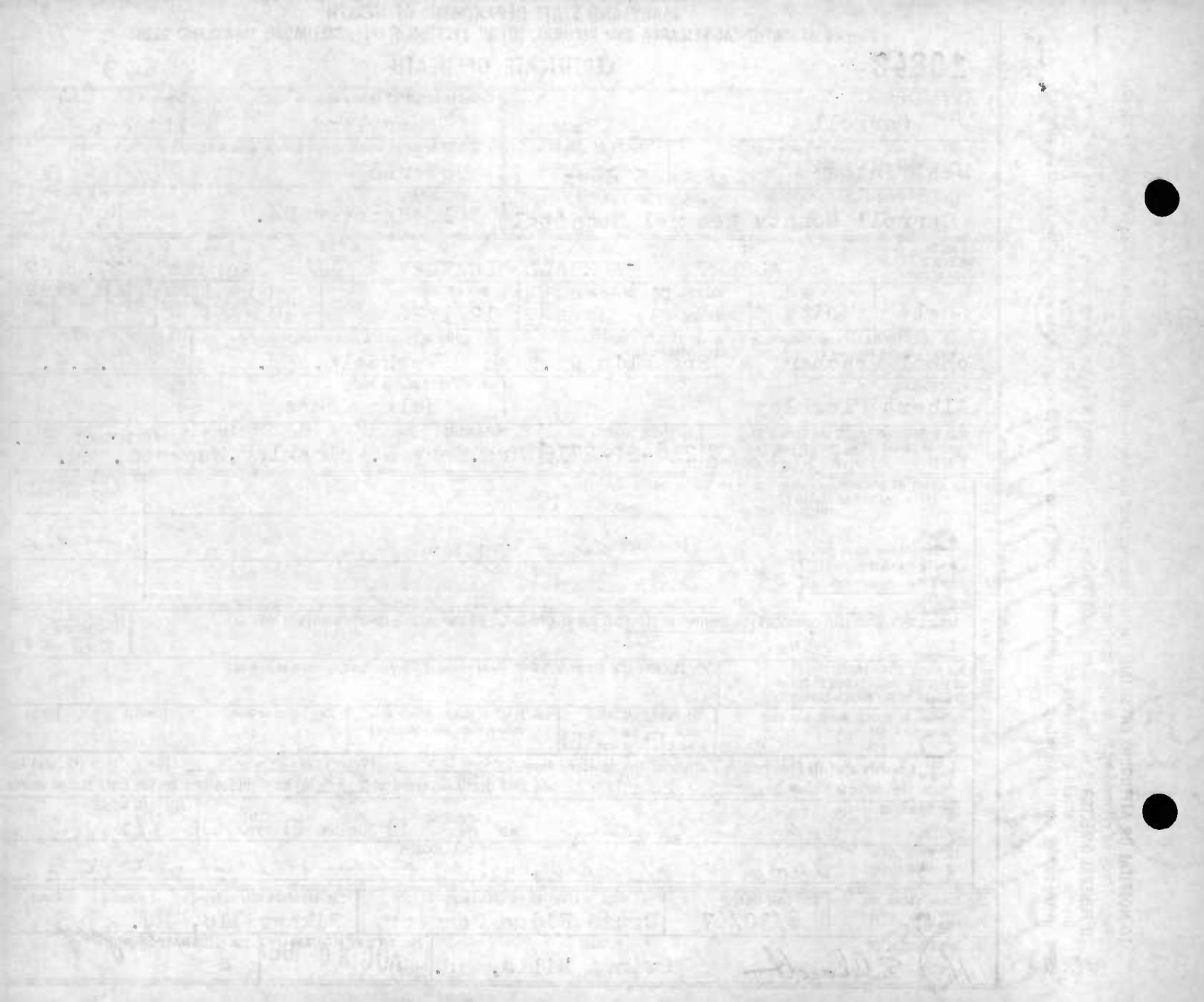
CERTIFICATE OF DEATH

10842

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	c. LENGTH OF STAY IN lb 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco 03.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		d. STREET ADDRESS Old Hanover Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT MARSHALL BLEAKLEY	First ALBERT	Middle MARSHALL	Last BLEAKLEY
4. DATE OF DEATH August 27, 1967	Month August	Doy 27	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/26
9. AGE (In years lost birthday) 40 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Franklin Jr. High	
11. BIRTHPLACE (County & State, or foreign country) Rockdale, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Bleakley		14. MOTHER'S MAIDEN NAME Helen Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II, Korea		16. SOCIAL SECURITY NO. 218-22-2715	
17. INFORMANT Mrs. Mary L. Bleakley		Address Old Hanover Rd., Upperco, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445 X DUE TO Ceremia INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO malignant hypertension (c) Emphysema			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pyelonephritis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. Aug 22, 1967		21. I certify that (I) (this hospital) attended the deceased from Aug 22, 1967 , to Aug 27, 1967 , that (I) (we) last saw the deceased alive on Aug 27, 1967 , and that death occurred at 9 1/2 M , from causes and on the date stated above.	
22a. SIGNATURE John S. Harshay		22b. DATE SIGNED 8/27/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHAY MD		22d. ADDRESS 1 Anchors St. Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/30/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Owings Mills, Md.		23d. LOCATION (City or Town) (County) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR H. J. Schindler		25a. REC'D. BY REGISTRAR DATE AUG 30 1967 25b. REGISTRAR'S SIGNATURE J. J. Johnson	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10844

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10844

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, New Windsor		c. LENGTH OF STAY IN lb 5 yrs +	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Norton Boarding Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED First JAMES Middle CHESTER Last BROTHERS		4. DATE OF DEATH AUG. 5 1967	
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	8. DATE OF BIRTH Oct. 21, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm labor - short		11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.	
13. FATHER'S NAME James Alfred Brothers		14. MOTHER'S MAIDEN NAME Susan Robertson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No, no, or unknown		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Wilson A. Dutrow, Reynard		Address Carroll Co. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO arteriosclerotic CVD Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED 21/5/67 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore (County) Maryland (State)	
21. I certify that (I) (this hospital) attended the deceased from 21/5/67 to 8/5/67, that (I) (we) last saw the deceased alive on 8/5/67, and that death occurred at 11:20 AM, from causes and on the date stated above.			
22a. SIGNATURE M.E. Robertson		22b. DATE SIGNED 8/5/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS New Windsor, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/18/67	
24. FUNERAL DIRECTOR J. E. Myers Jr., Westminister, Md.		23c. NAME OF CEMETERY OR CREMATORIAL Meadow Brook Cemetery, Rural Westminster, Md.	
ADDRESS		23d. LOCATION (City or Town) (County) (State)	
		25a. REC'D BY REGISTRAR J. E. Myers Jr., Westminister, Md.	
		25b. REGISTRAR'S SIGNATURE J. E. Myers Jr., Westminister, Md.	
		DATE AUG 8 1967	

RECEIVED - 1968

5201

DEPARTMENT OF DEFENSE



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DERT.

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File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

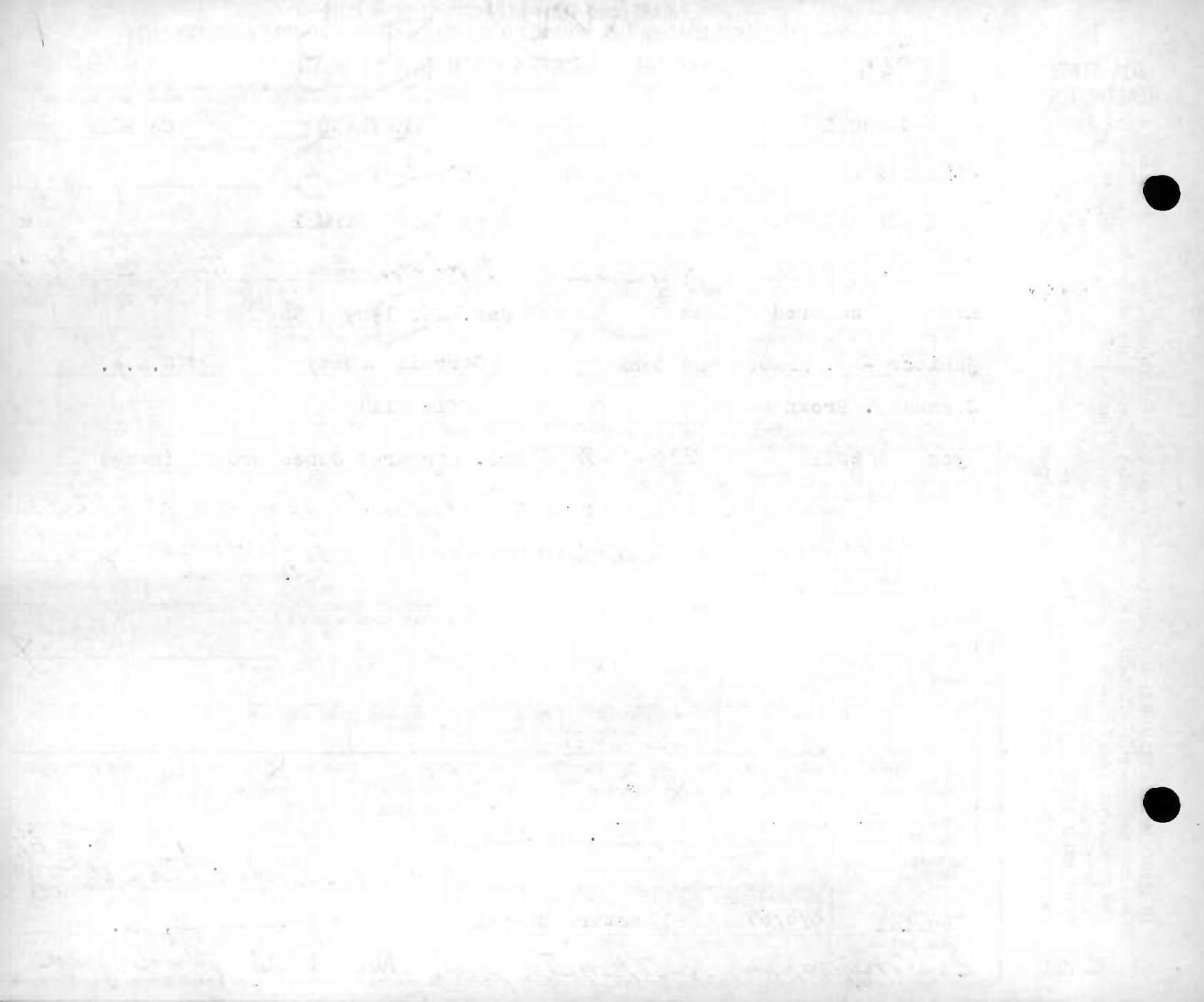
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Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

3
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

4
Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10845		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						10845					
1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN lb 40 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		d. STREET ADDRESS 59 UNION STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LONGWELL AVENUE													
3. NAME OF DECEASED (Type or print) DAVID First Middle Lost		4. DATE OF DEATH 8 - 2 - 1967		5. AGE (In years last birthday) 58 yrs.		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1909		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) janitor - St. Armory and Bank		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll County		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joshua W. Brown		14. MOTHER'S MAIDEN NAME Effie Hill											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 220-01-7055		17. INFORMANT Mrs. Margaret Jones Brown (same)		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (acute) INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. short time 4201 (b) Arteriosclerotic Cardiovascular disease Several yrs DUE TO DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED 8-2-67			
ACTUAL SIGNATURE <i>W. E. Myers Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Add'l. (Signature) <i>W. E. Myers Jr.</i> <i>Westminster, Md.</i>											
EXAMINER'S NAME (Type) burial		23b. DATE THEREOF 8/14/67		23c. NAME OF CEMETERY OR CREMATORIAL Western Chapel		23d. LOCATION (City or Town) (County) (State)							
24. FUNERAL DIRECTOR <i>J. E. Myers Jr., Westminster, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 4 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10846

CERTIFICATE OF DEATH

10846

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~funeral papers~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll Sykesville MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland Washington ✓ b. COUNTY Hagerstown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 14 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown,		d. STREET ADDRESS N. Prospect St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Morris		First A. Middle Arthur	Lost Burger
4. DATE OF DEATH Month August Doy 2 Year 1967	5. SEX M		6. COLOR OR RACE W
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27-97	
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Doy <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Doy <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Washington County, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jake Burger		14. MOTHER'S MAIDEN NAME Mary Winters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-54-2323	
17. INFORMANT Mr. John Burger		Address 2112 Evergreen Dr. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Ins. cardiac</i>		INTERVAL BETWEEN ONSET AND DEATH	
4500 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <i>Malnutrition</i>			
DUE TO (c) <i>Generalized arteriosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 7-17 , 19 67 , to 8-2 , 19 67 , that (I) (we) last saw the deceased alive on 8-2 , 19 67 , and that death occurred at 4:55 P.M. , from causes and on the date stated above.		22b. DATE SIGNED 8-2-67	
22a. SIGNATURE <i>Jose I. Alsina</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. PHYSICIAN'S NAME (Type) Jose I. Alsina
22d. ADDRESS Springfield State Hospital		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 8-5-67		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	
24. FUNERAL DIRECTOR <i>Charles E. Rivera, Jr.</i> Rest Haven Funeral Chapel Inc., Hagerstown, Md.		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Maryland	
ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
DATE		DATE AUG 7 1967	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 2 hours after death.

10847

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10847

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN Tb 9 days	b. COUNTY Baltimore City				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital, Sykesville, Md. 1312 Eutaw Place		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3014					
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Virgil	Middle A.	4. DATE OF DEATH Calvin	Month August	Doy 10	Year 1967
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED Unk.	NEVER MARRIED DIVORCED Unk.	B. DATE OF BIRTH 2-10-14	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. DAYS Hours 10
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Mary V. (last name unknown)		15. INFORMANT Springfield Hospital Records, Sykesville, Md.			
16. SOCIAL SECURITY NO. unknown							
17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Bronchopneumonia & acute pericarditis due to INTERVAL BETWEEN ONSET AND DEATH Days 491X DUE TO organism not determined Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1385 Main Westmister Rd	(County) Carsel	(State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Glenn Speicher, M. D.							
EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.							
23a. BURIAL, CREMATION, REMAINS, ETC. Burial		23b. DATE THEREOF 8/12/67	23c. NAME OF CEMETERY OR CREMATORIUM Mt Calvary Cemetery	23d. LOCATION (City or Town) A A County Md			
24. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	25a. REC'D BY REGISTRAR DATE AUG 15 1967				
			25b. REGISTRAR'S SIGNATURE Charles Juge				

— 6 —

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10848

CERTIFICATE OF DEATH

10848

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			b. COUNTY <u>Baltimore City</u>		
c. LENGTH OF STAY IN lb <u>1 mos. 25 dya.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>			d. STREET ADDRESS <u>721 S. Bond St.</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <u>LOUIS</u>	Middle (NMN) <u></u>	Last <u>CIERI</u>	4. DATE OF DEATH <u>AUGUST 1 1967</u>	Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>7-11-1887</u>	9. AGE (In years (1st birthday) 80 yrs.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor (Ret.)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>	12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>
13. FATHER'S NAME <u>Angelo Cieri</u>			14. MOTHER'S MAIDEN NAME <u>Unk.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-6766</u>		17. INFORMANT <u>Records, Springfield State Hospital</u>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema and bronchopneumonia</u> INTERVAL BETWEEN ONSET AND DEATH 163X Days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of left lung with metastases to kidneys</u> Months or year (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-6-67</u> , 19 <u>to 8-1-67</u> , 19 <u>that (I) (we) last saw the deceased alive on <u>8-1-67</u>, 19<u>, and that death occurred at <u>8:40 AM</u> M, from causes and on the date stated above.</u></u>					
22a. SIGNATURE <u>Julian Radzykewycz</u>					
22b. DATE SIGNED <u>8-1-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Julian Radzykewycz, M. D.</u>		22d. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Glen Haven Mem. Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR <u>George B. Glancy</u>		ADDRESS <u>Singleton Funeral Home</u>	25a. REC'D. BY REGISTRAR <u>AUG 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

INTERVIEW WITH JAMES LEE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10849

CERTIFICATE OF DEATH

10849

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> c. LENGTH OF STAY IN 1b <u>10 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1st Ave Sykesville, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Guest Home</u>		d. STREET ADDRESS <u>1st Ave.</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED First <u>Ernest</u> Middle <u>-</u> Last <u>Cole</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>June 21, 1894</u>		9. AGE (In years lost birthday) <u>73 yrs.</u> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Robert Killett</u> Address <u>Sykesville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>332x</u> DUE TO <u>Cerebral hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO <u>Chr. Cardiac dysfunction</u> (c) DUE TO <u>Gul attack of disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>Aug</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u> (County) <u>Md.</u> (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1967</u> to <u>Aug 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 12, 1967</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. Martin</u>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <u>Aug 14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. N. MARTIN</u>		22d. ADDRESS <u>Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-15-67</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>New Freedom</u>		23d. LOCATION (City or Town) <u>Sykesville</u> (County) <u>Md.</u> (State)	
24. FUNERAL DIRECTOR ADDRESS <u>Harry W. Height Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 17 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>	

6500

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.8
M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

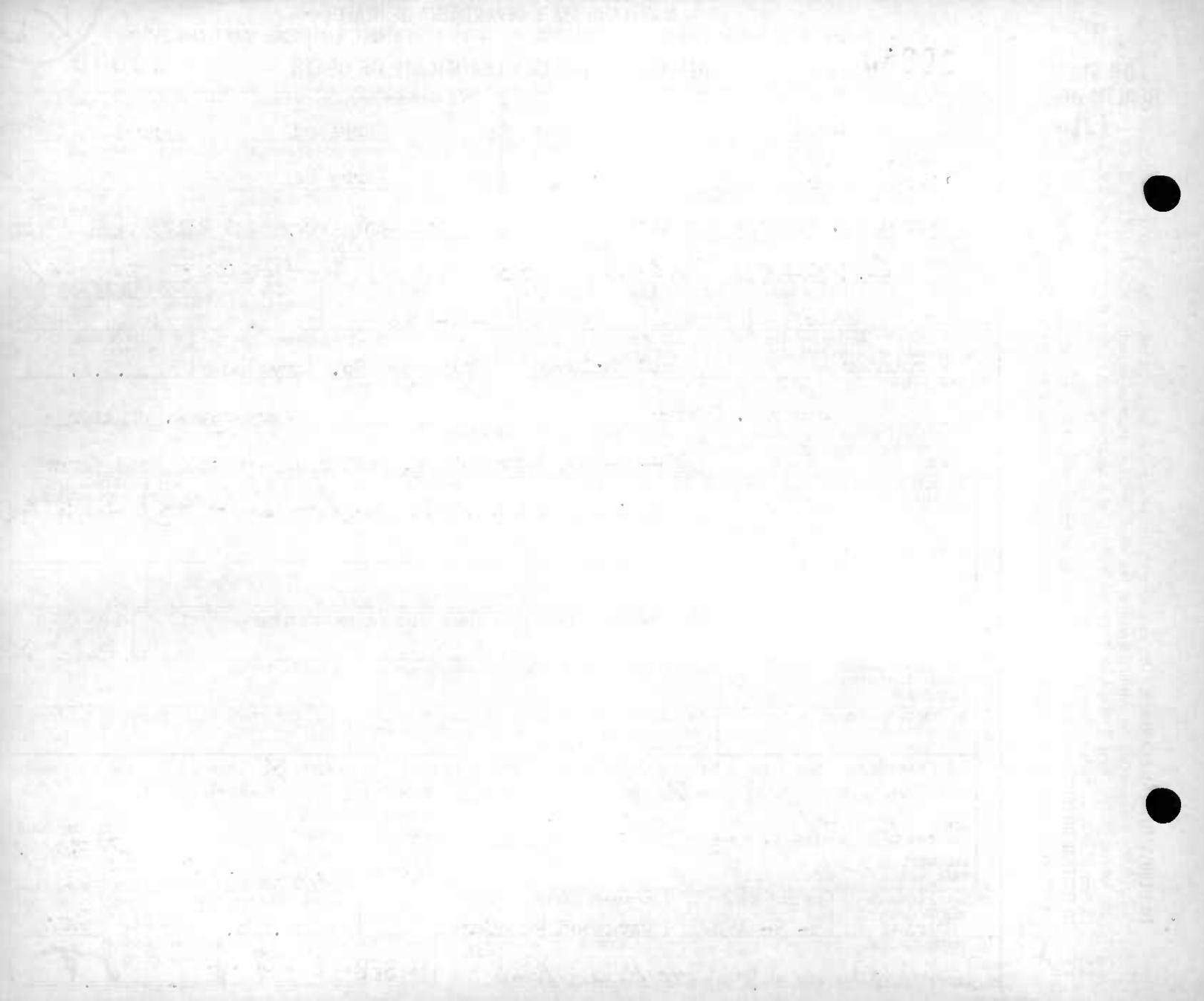
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

10850

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10850

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospital		d. STREET ADDRESS Snyder Lane Perry Hall 21128	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LINGARD JACOB COSTER		First L	Middle I
Last C		4. DATE OF DEATH AUGUST 30 1967	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-21-1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	9. AGE (In years last birthday) 51 yrs.
13. FATHER'S NAME Henry B. Coster		11. BIRTHPLACE (State or foreign country) Baltimore Co. Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 220-07-7675		17. INFORMANT Mr John H. Coster 4265 Chapel Road Perry	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William Spicker, M.D.		22. DATE SIGNED 8/30/67	
EXAMINER'S NAME (Type) William Spicker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address: 1355 E. 34th Street, Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-5-1967	23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 B. Laird Road		ADDRESS 36	25a. REC'D BY REGISTRAR Charles J. Judge
		DATE SEP 5 1967	25b. REGISTRAR'S SIGNATURE Charles J. Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

9 1
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10851

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10851

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westminster		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westminster		d. STREET ADDRESS R. D. 6		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R. D. 6						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>FRANCIS</i>	Middle <i>JESSE</i>	Lost	4. DATE OF DEATH 8 - 17 1967	Month 8	Day 17	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 23, 1909	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Francis A. Crawford				14. MOTHER'S MAIDEN NAME Ethel J. Hooper				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-7163		17. INFORMANT Mrs. M. Hollus Crawford		Address Same As #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) 260 X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<i>Coronary Thromboses (acute)</i>		INTERVAL BETWEEN ONSET AND DEATH Sudden		
(b)		DUE TO		<i>Arterio-sclerotic Heart Disease</i>		Generally		
(c)				<i>Alcoholism Mellitus</i>		3 1/2 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>W. Glenn Speicher</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) W. Glenn Speicher		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
		Address: 135 E. Main Street, Westminster, Carroll Co., Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/20/1967		23c. NAME OF CEMETERY OR CREMATORIAL St. James Cemetery		23d. LOCATION (City or Town) (County) Carroll Co., Md.		
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 21 1967		25b. REC'D BY CLERK'S SIGNATURE <i>John C. Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

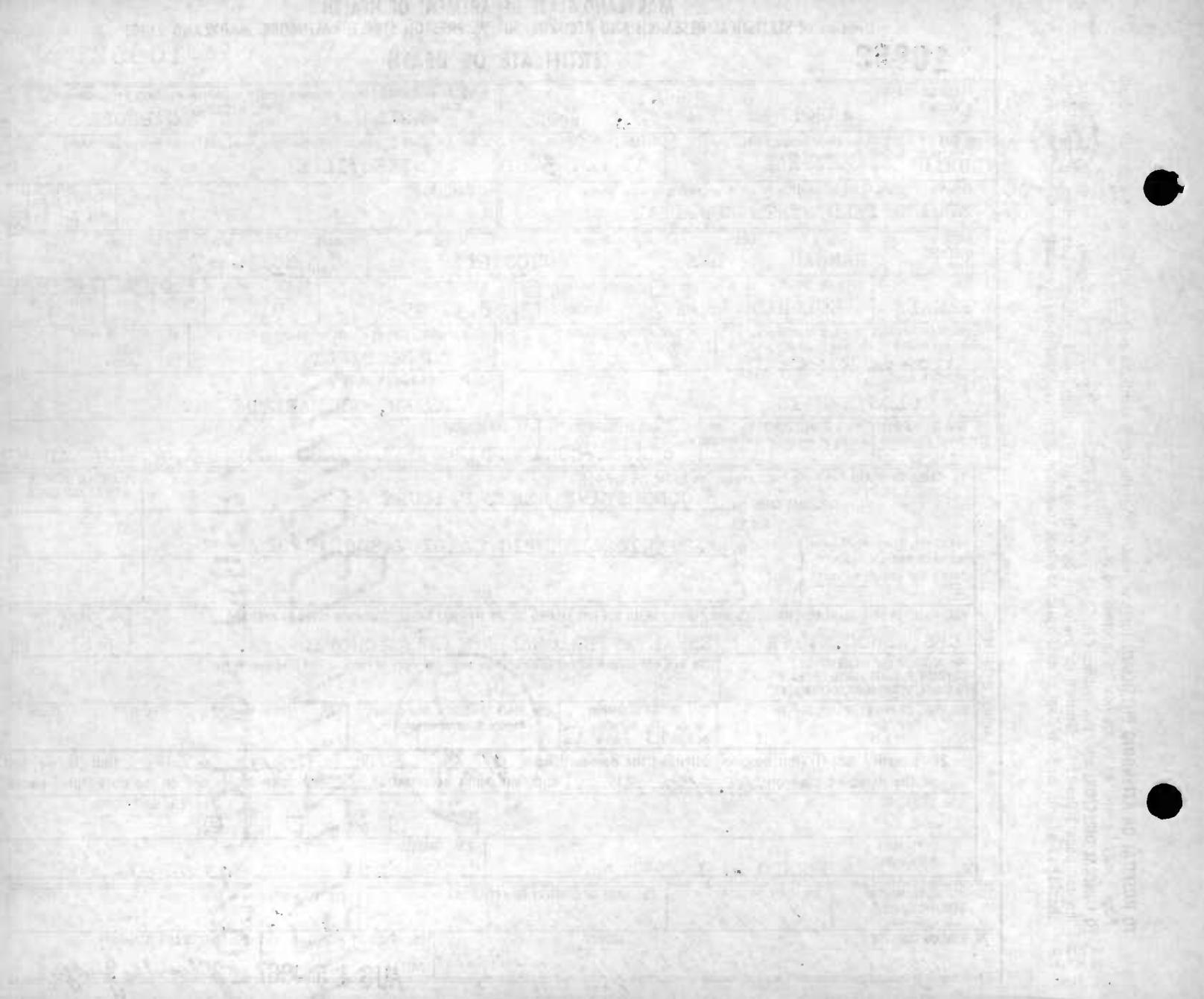
MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10852

CERTIFICATE OF DEATH

10852

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SYKESVILLE		c. LENGTH OF STAY IN lb II MO. 5 DYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First HANNAH	Middle LEE	Lost CROCKETT	4. DATE OF DEATH	Month 8-13-67 Doy 19 Year 19
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8 31 95	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 0 Doy 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) CONNECTICUT	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME OLDS, BERTIE			14. MOTHER'S MAIDEN NAME JESTER, ELIZABETH		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 042-32-8091		17. INFORMANT Address SPRINGFIELD STATE HOSP., SYKESVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) CONGESTIVE HEART FAILURE			INTERVAL BETWEEN ONSET AND DEATH		
4221 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.			DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CBS ASSOC. WITH CEREBRAL ARTERIOSCLEROSIS ^c PSYCHOTIC REA.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/18/66, 19, to 8/13/67, 19, that (I) (we) last saw the deceased alive on 8/13/67, 19, and that death occurred at 9 AM, from causes and on the date stated above.					
22a. SIGNATURE Alfredo M. Labrit		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-13-1967	
22c. PHYSICIAN'S NAME (Type) X ALFREDO M. LABRIT M.D.		22d. ADDRESS SYKESVILLE SPRINGFIELD STATE HOSPITAL, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/17/67		23c. NAME OF CEMETERY OR CREMATORIAL Northwood	
24. FUNERAL DIRECTOR Mr. J. Schatzman b-1901 m-? c-1967		ADDRESS		25a. REC'D BY REGISTRAR Hartford, Conn.	
25b. REGISTRAR'S SIGNATURE		DATE AUG 15 1967		Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10853

CERTIFICATE OF DEATH

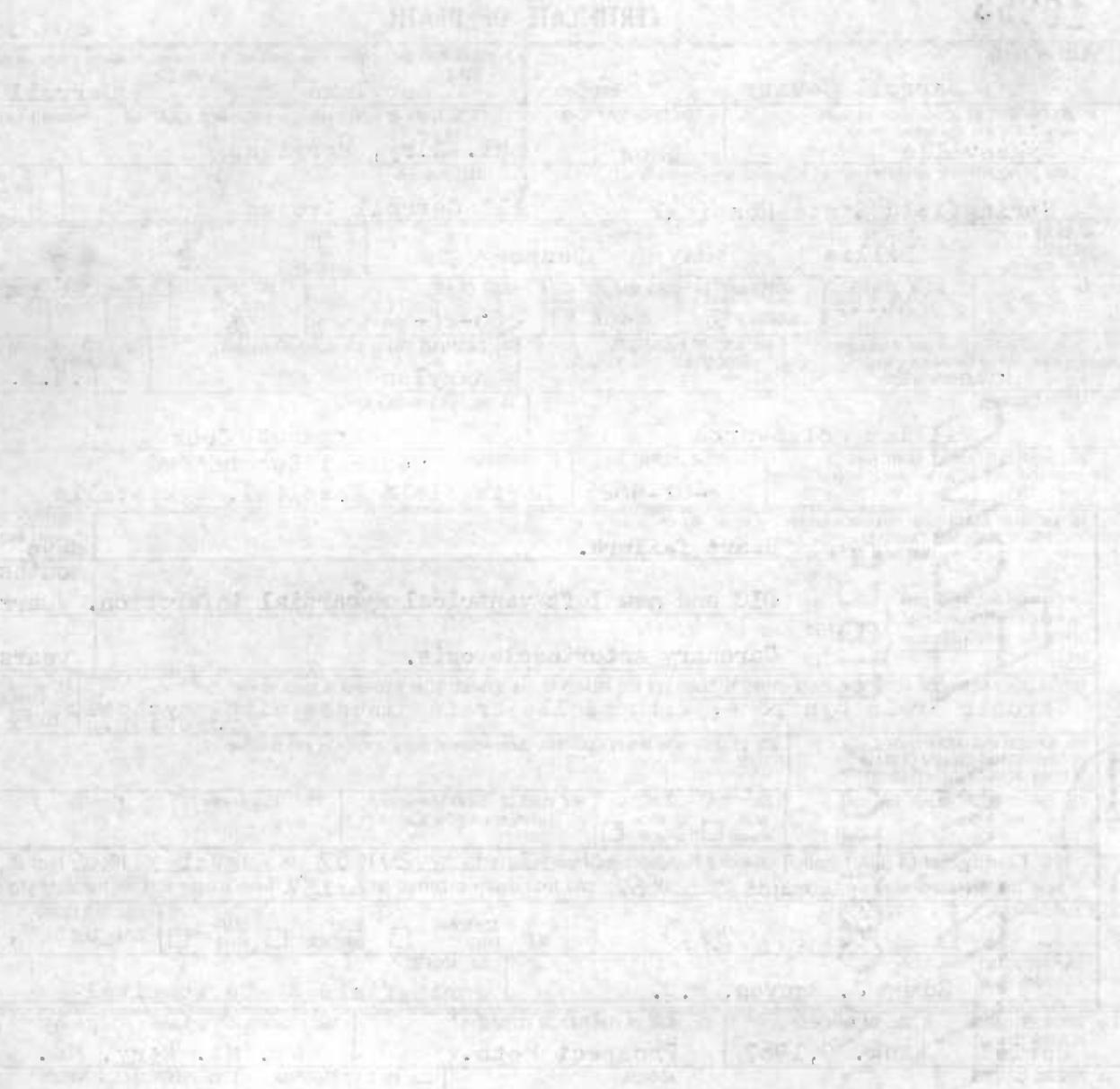
10853

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll County Maryland			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN Tb 8mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy, Maryland							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 111 Carroll Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lillie May Deppsey		First	Middle	Lost	4. DATE OF DEATH 18	Month 7	Doy 19	Year 67			
S. SEX F	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 06-28-91	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Molesworth			14. MOTHER'S MAIDEN NAME Margaret Cook								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-5626		17. INFORMANT Medical Record Address Springfield Hospital, Sykesville							
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Heart failure.									INTERVAL BETWEEN ONSET AND DEATH days 4201		
DUE TO (b) Old and new left ventrical myocardial infarction. years									months &		
DUE TO (c) Coronary arteriosclerosis. years									years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Chronic Brain Syndrome, with senile brain disease with psychotic reaction.									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 20 1967 to August 7, 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 7 1967 , and that death occurred at 6:15 P.M. from causes and on the date stated above.									22b. DATE SIGNED August 7, 1967		
22a. SIGNATURE Edmee J. Reeves, M.D.									M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M.D.									22d. ADDRESS Springfield State Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 9, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Prospect Meth.			23d. LOCATION (City or Town) (County) (State) Nr. Mt. Airy, Md.				
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.									ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
									DATE AUG 11 1967		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

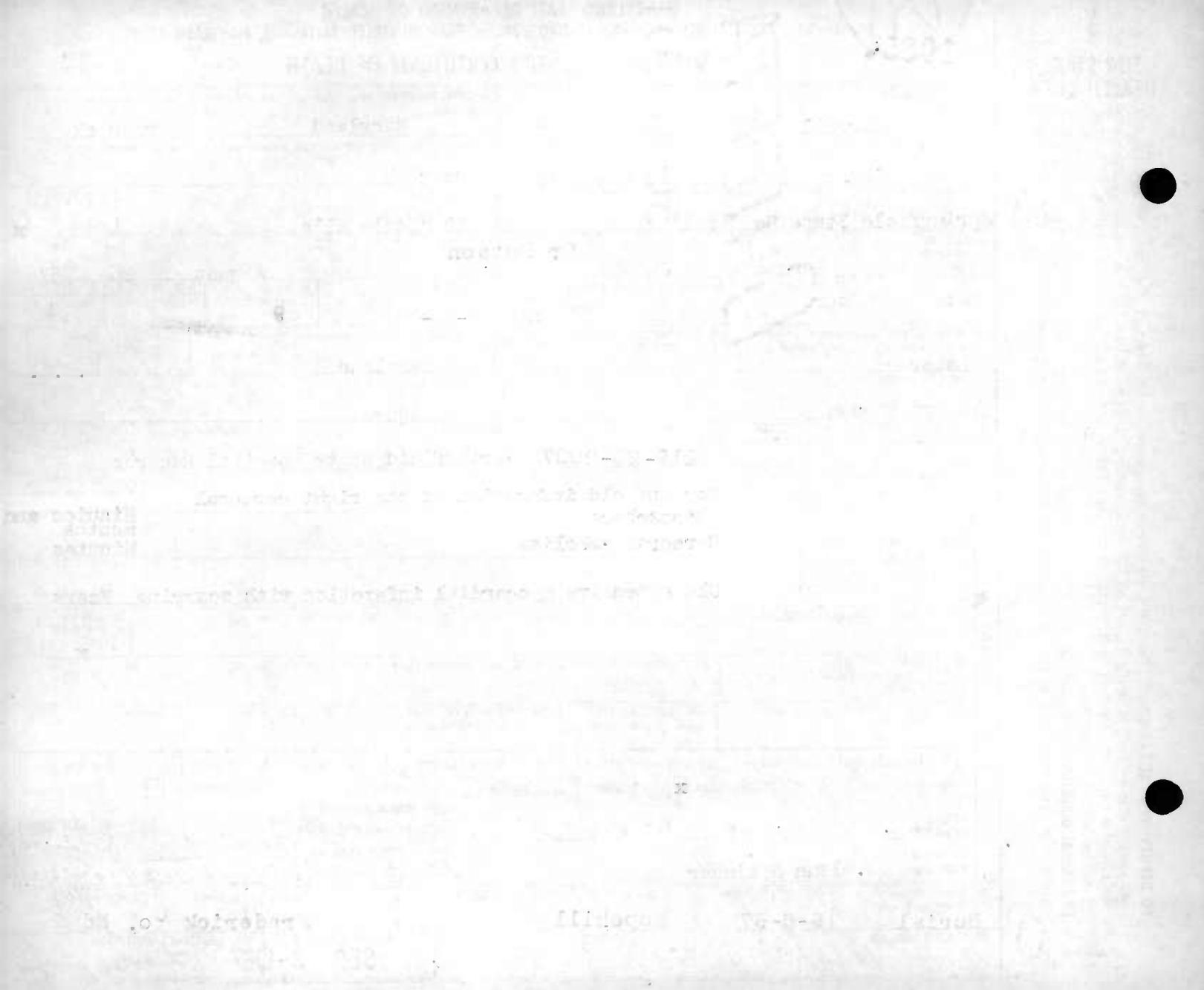
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

10854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10854

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Fredrick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1mo 5 da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fredrick		d. STREET ADDRESS 112 Middle Alley	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herman		First	Middle	Or Dotson	Lost	4. DATE OF DEATH August 25	Month Year 1967
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-22-08	9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS. Days Hours Min. 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Dobson				14. MOTHER'S MAIDEN NAME Agnes		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-2007		17. INFORMANT Springfield State Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) New and old infarction of the right cerebral hemisphere DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Cerebral embolism DUE TO (b) DUE TO (c) Old extensive myocardial infarction with scarring INTERVAL BETWEEN ONSET AND DEATH Minutes and months Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Co., Md.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Glenn Speicher		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 8-25-67	
EXAMINER'S NAME (Type) W. Glenn Speicher		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address 133 Chestnut Street, Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-67	23c. NAME OF CEMETERY OR CREMATORIUM Hopehill	23d. LOCATION (City or Town) Frederick Co., Md.	(County) Md.	(State) Md.	
24. FUNERAL DIRECTOR G.E. Hicks III		ADDRESS Frederick, Md.		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE		
				DATE 9 SEP 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10855

CERTIFICATE OF DEATH

10855

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 4½ years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 1216 Lafayette Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Ulva (Elsa) Elsie		Middle Dyer	4. DATE OF DEATH August 8 1967	Month August	Day 8
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-1886	9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME John K. White			14. MOTHER'S MAIDEN NAME Frances Wolford		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-14-5882		17. INFORMANT Medical Record Address Springfield State Hospital, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure INTERVAL BETWEEN ONSET AND DEATH 4211 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Mitral Valve Stenosis DUE TO Coronary arteriosclerosis. Bilateral bronchial pneumonia years DUE TO COPD DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic Brain Syndrome associated with cerebral arteriosclerosis with psychotic reaction.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield	(County) Allegany
21. I certify that 10 (this hospital) attended the deceased from October 18, 1962 , to August 8, 1967 , that 10 (we) last saw the deceased alive on August 8, 1967 , and that death occurred at 8 A.M. from causes and on the date stated above.					
22a. SIGNATURE <i>Edm J. Reeves</i>		22b. DATE SIGNED 8-8-67			
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M.D.		22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 11, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/66		DATE AUG 10 1967			

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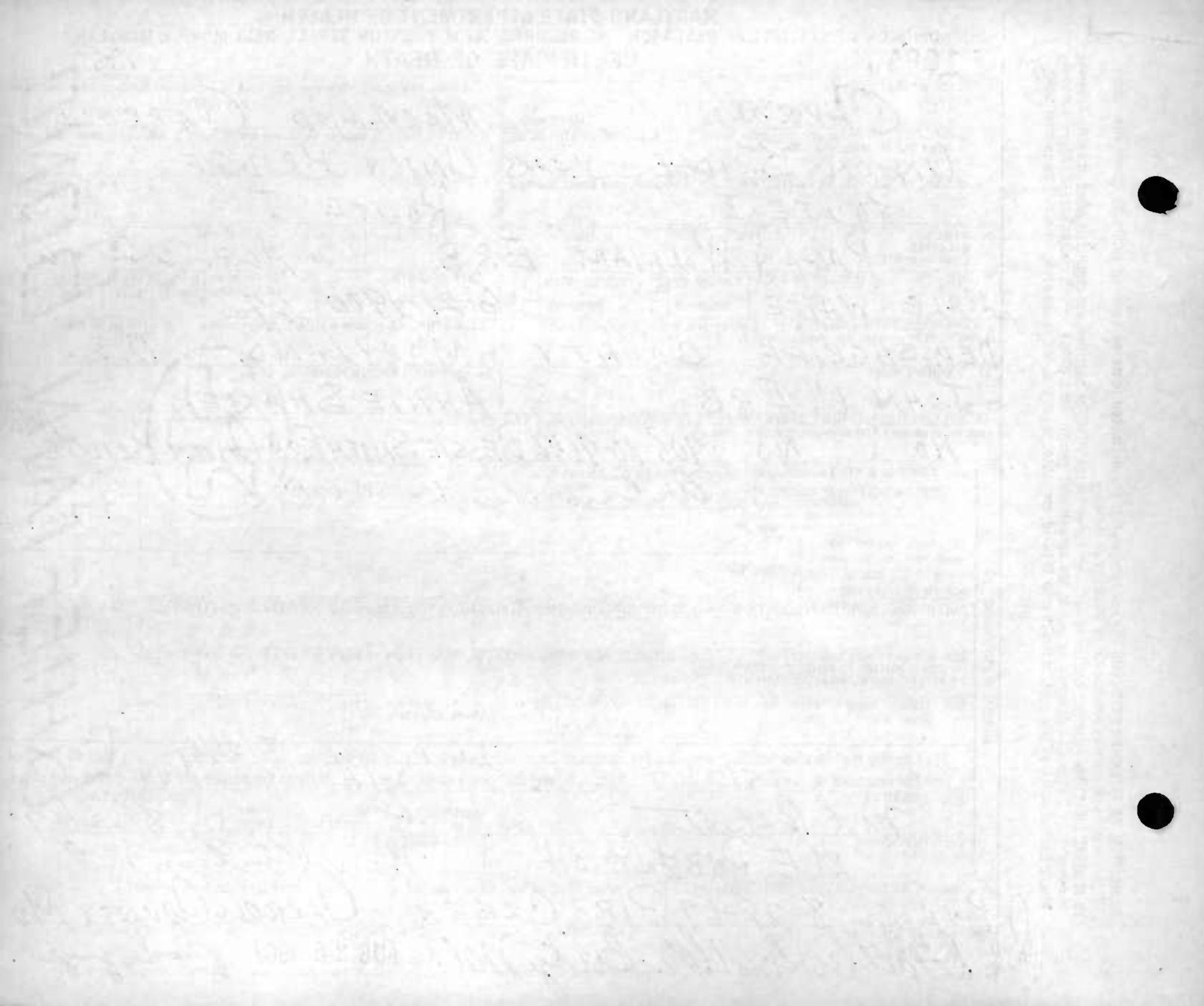
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10856

CERTIFICATE OF DEATH

10856

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY	
CARROLL MARYLAND		MARYLAND CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE YEARS		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE I	
d. STREET ADDRESS ROUTE I		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First RAGAN	Middle WILLIAM	Last ERB
4. DATE OF DEATH	Month AUG. 22	Day 1967	Year 1967
5. SEX	6. COLOR DR RACE MALE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEP. SHERIFF	10b. KIND OF BUSINESS DR INDUSTRY COUNTY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME JOHN V. ERB	14. MOTHER'S MAIDEN NAME ANNIE SHAMER	Address M.D. BESSIE SMITH ERB, UNION BRIDGE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY ND. No	17. INFORMANT Arteriosclerotic C.V.D.	INTERVAL BETWEEN ONSET AND DEATH 3 years
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H221		DUE TO (b) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1964, to 8/22/67, that (I) (we) last saw the deceased alive on 8/12/67 19, and that death occurred at 1A M, from the causes and on the date stated above.		22b. DATE SIGNED 8/22/67	
22a. SIGNATURE M.E. Robertson		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS New Windsor, Md	
22c. PHYSICIAN'S NAME (Type) M.E. ROBERTSON		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
		23b. DATE THEREOF 8-25-67	23c. NAME OF CEMETERY OR CREMATORIUM PIPE CREEK
		23d. LOCATION (City, town or county) CARROLL COUNTY MD	(State)
24. FUNERAL DIRECTOR D. Fletcher Union Bridge Md.		25a. REC'D BY REGISTRAR AUG 25 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10857

10857

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville		d. STREET ADDRESS Route 4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 4				d. STREET ADDRESS Route 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Foster Gary Friend		First	Middle	Lost	4. DATE OF DEATH August 17, 1967	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-1901	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Cornelius Friend				14. MOTHER'S MAIDEN NAME Lizzie Friend				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT ? Mrs. Edith Friend		Address Sykesville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 Conditions, if any, which goe rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) DUE TO (c)		CARDIAC FAILURE INOPERABLE C. of Colon. 4 MO.		INTERVAL BETWEEN ONSET AND DEATH 20 min.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Garrett Co.	(County) Md.	(State) Md.		
21. I certify that I attended the deceased from alive on APRIL 1, 1967 to Aug. 17, 1967 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Sykesville, Md.			DATE SIGNED 8-17-67			
ACTUAL SIGNATURE R. V. Houck Jr.		M.D.						
PHYSICIAN'S NAME (Type)		Sykesville, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-67		22c. NAME OF CEMETERY OR CREMATORIUM Blooming Rose Cemetery		22d. LOCATION (City, town, or county) Garrett Co.		
(State) Md.								
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Haight		ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE AUG 21 1967		24b. REGISTRAR'S SIGNATURE Judge		

BRUNSWICK
WILHELM
KARL

PRINTED IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10858

CERTIFICATE OF DEATH

10858

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		
c. LENGTH OF STAY IN lb 24 YRS			d. STREET ADDRESS 72 WINCHESTER AVE.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 72 WINCHESTER AVE.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First MATTIE	Middle MISSOURI	Last FROCK	4. DATE OF DEATH	Month AUG. Day 24 Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 18 1875	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DANIEL J. CRUMBACKER			14. MOTHER'S MAIDEN NAME ANNA BARBARA GREENWOOD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-16-8245		17. INFORMANT MR. MARSHALL CRUMBACKER MD	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis - Generalized DUE TO 146X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nasopharyngeal Carcinoma DUE TO (c)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rural New Windsor (County) MD (State) MD	
21. I certify that (I) (this hospital) attended the deceased from 12-9 , 1964, to 8/24 , 1967, that (I) (we) last saw the deceased alive on 8/19 , 1967, and that death occurred at 7145M , from causes and on the date stated above.					
22a. SIGNATURE Philip W. Mercer M.D.			22b. DATE SIGNED 8/26/67		
22c. PHYSICIAN'S NAME (Type) PHILIP W. MERCER			22d. ADDRESS 150 W. Main St. Westminster MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/26/67	23c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK CEM.	23d. LOCATION (City or Town) (County) (State) Rural New Windsor, MD	
24. FUNERAL DIRECTOR J. E. Myers Jr., WESTMINSTER, MD		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge

6331

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10853

10859

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Middleburg

10 months

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Brookfield Manor Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Maggie

Dean

Gagel

4. SEX

5. COLOR OR RACE

Female

White

6. MARRIED NEVER MARRIED 7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

March 12th 1875

92 yrs.

9. AGE (In years
last birthday)10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (County & State, or foreign country)

Carroll Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Giles Fair

14. MOTHER'S MAIDEN NAME

Margaret Ann Kuhns

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

215-54-0556 Mrs. Harry Haines, Uniontown, Maryland

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebro Vascular accident

INTERVAL BETWEEN
ONSET AND DEATH

3 1/2 wks

331X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Cerebral atherosclerosis + thrombosis

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

p.m.

19

20d. INJURY OCCURRED

While Not While

at work at work

21. I certify that (I) (this hospital) attended the deceased from

10/27/66

19....., to 8/29/67

19....., that death occurred at 8P.M.

from the causes and on the date stated above.

22a. SIGNATURE

J. H. Caricofe, M.D.

22b. ADDRESS

Union Bridge, Maryland 21791

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

Sept. 1, 1967

Lutheran Cemetery

23b. DATE THEREOF

ADDRESS

Taneytown, Maryland

23d. LOCATION (City, town or county)

(State)

Uniontown, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

C.O. Fuss & Son,

ADDRESS

Taneytown, Maryland

25a. REC'D BY REGISTRAR

SEP 1 1967

j Charles Judge

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B.D.

VR A15 (4)
1SM 7/61

RECORDED

1932

SEARCHED INDEXED

SERIALIZED FILED

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10860

CERTIFICATE OF DEATH

10860

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frank J. Gais		d. STREET ADDRESS Hampstead	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank J. Gais		First	Middle
4. DATE OF DEATH August 18, 1967		Lost	Month
5. SEX Male		Day	Year
6. COLOR OR RACE White		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1899	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (County & State, or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Gais		14. MOTHER'S MAIDEN NAME Anna Schrank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-18-903QA	
17. INFORMANT Mrs. Theresa Macheck		Address Hampstead, Md. 21074	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Insufficiency DUE TO (c) Arterio-Sclerosis		3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hampstead
20f. (City or town) Hampstead (County) Md. (State) U.S.A.			
21. I certify that (I) (this hospital) attended the deceased from July 20, 1964 , to Aug. 18, 1967 , thor (I)(we) lost saw the deceased alive on 7-29 1967 , and that death occurred at 3p . M, fram causes and an the date stated above.		22b. DATE SIGNED 8/19/67	
22c. PHYSICIAN'S NAME (Type) Maurice C.P. Porterfield, M.D.		22d. ADDRESS Hampstead, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery		23d. LOCATION (City or Town) Baltimore City, Md. (County) Md. (State) U.S.A.	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home		ADDRESS Hampstead, Md.	
25a. REC'D BY REGISTRAR AUG 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1940-40-50000002

peasant

peasant

poor

poor

middle class

middle class

middle class

middle class

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10861

CERTIFICATE OF DEATH

10861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 24 yrs. 2 mos. 9 days.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES		First A.	Middle GARY
4. DATE OF DEATH AUGUST 18	Month 1967	Doy 19	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-21-23		9. AGE (In years lost birthday) 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR ?INDUSTRY???	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel F. Gary		14. MOTHER'S MAIDEN NAME Frances Reely	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 121-22-6279?	17. INFORMANT Address Records, Springfield State Hospital
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Renal failure due to suppurative nephritis, bilateral DUE TO 600.0		INTERVAL BETWEEN ONSET AND DEATH Weeks Months & years	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost: } DUE TO } (b) Heart failure due to adhesive pericarditis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CBS assoc. with convulsive disorder, with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) vital signs	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Towson		(County) (State) Baltimore Co. Md.	
21. I certify that (I) (this hospital) attended the deceased from 6-9-63 , 19 8-18-67 , 19, that (I) (we) last saw the deceased alive on 8-18-67 , 19, and that death occurred at 8:45 AM , from causes and on the date stated above.		22b. DATE SIGNED 8-18-67	
22c. PHYSICIAN'S NAME (Type) Dr. Antonius Glahn		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS Springfield State Hospital
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23c. NAME OF CEMETERY OR CREMATORIALY Green Mount Crematory	
23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc., Towson, Md. 21204		ADDRESS	25a. REC'D BY REGISTRAR DATE AUG 24 1967
			25b. REGISTRAR'S SIGNATURE James Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10862

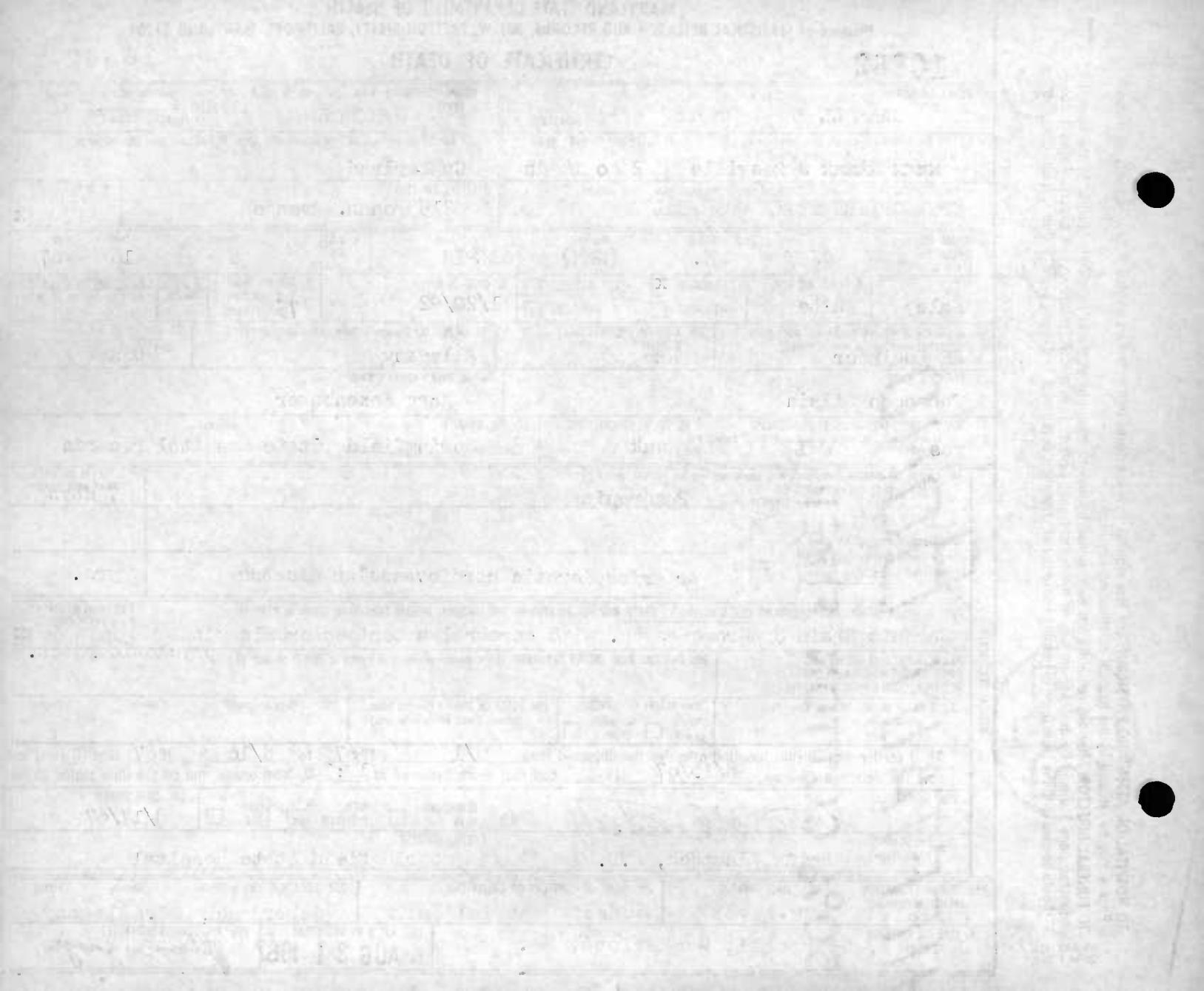
CERTIFICATE OF DEATH

10862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENVILLE Sykesville		c. LENGTH OF STAY IN lb 2 mo 16 da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL				d. STREET ADDRESS 215 Penna. Avenue				
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) OKEY		First W.	Middle (NMN)	Lost GILPIN	4. DATE OF DEATH 1/20/92	Month 8	Doy 16	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/92	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RR Engineer			10b. KIND OF BUSINESS OR INDUSTRY RR		11. BIRTHPLACE (County & State, or foreign country) Allegany			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thompson Gilpin				14. MOTHER'S MAIDEN NAME Mary Fazenbaker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WWI unk		17. INFORMANT Springfield State Hospital records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Pneumonia								INTERVAL BETWEEN ONSET AND DEATH 1 days
4221 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) _____ DUE TO _____ (c) Arteriosclerotic cardiovascular disease DUE TO _____ yrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Chronic Brain Syndrome assoc. with cerebral arteriosclerosis with psychotic react.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) psychotic react.						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) Springfield (County) State		
21. I certify that (I) (this hospital) attended the deceased from 6/1 , 19 67 to 8/16 , 19 67 , that (I) (we) last saw the deceased alive on 8/16/67 19 67 , and that death occurred at 10:30 AM from causes and on the date stated above.								
22a. SIGNATURE Heinz Klaatsch		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/17/67		
22c. PHYSICIAN'S NAME (Type) Heinz Klaatsch, M.D.		22d. ADDRESS Springfield State Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 19, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE AUG 21 1967 Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10863

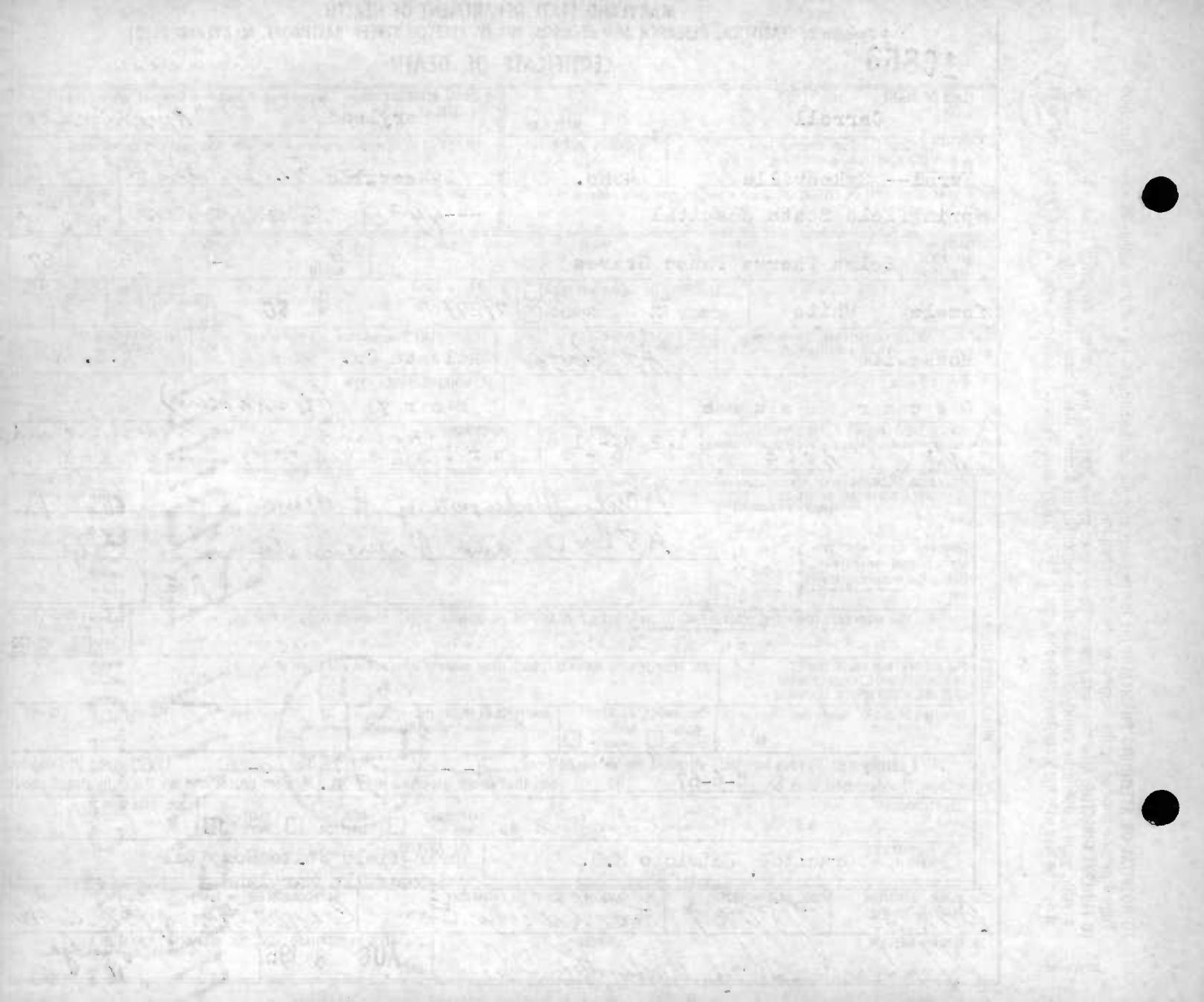
CERTIFICATE OF DEATH

10863

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Sykesville	c. LENGTH OF STAY IN lb 4 Mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville SILVER SPRING 152	d. STREET ADDRESS ---449 EAST UNIVERSITY BLVD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED First Middle Last		4. DATE OF DEATH Month Day Year 8- 6 1967		
S. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/27/87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (County & State, or foreign country) Atlanta Ga.	
13. FATHER'S NAME Oscar Pause		14. MOTHER'S MAIDEN NAME Mary (Unknown)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 618-57-16	17. INFORMANT Records Address SYKESVILLE, MD, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO ASCVD and Pneumonitis (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4-6 hr days. (RE)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) S.B.S. assoc. with Senile brain disease with Psychotic reaction				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-6, 1967, to 8-6, 1967, that (I) (we) last saw the deceased alive on 8-6-67 19, and that death occurred at 7 a.m. from causes and on the date stated above.				22b. DATE SIGNED 8-5-67
22a. SIGNATURE Gracito V. Patricio M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> S. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 8-5-67	
22c. PHYSICIAN'S NAME (Type) Gracito V. Patricio M.D.		22d. ADDRESS Springfield State Hospital Sykesville Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/8/67	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Prince George's Co.
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D. BY REGISTRAR AUG 8 1967	25b. REGISTRAR'S SIGNATURE Charles J. Judge
Burke Funeral Home, Washington, D.C.		DATE		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10864

10864

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1mo. 9dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Keedysville		d. STREET ADDRESS Route #1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GLADYS		First IRENE	Middle GRIFFITH	Lost	4. DATE OF DEATH AUGUST 21 1967	Month	Doy	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-18-12	9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Roy G. Griffith				14. MOTHER'S MAIDEN NAME Emma Orcutt					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-38-2395		17. INFORMANT Records, Springfield State Hospital		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Bronchopneumonia DUE TO 4221						INTERVAL BETWEEN ONSET AND DEATH Days			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease with failure DUE TO (c)						Years			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that (I) (this hospital) attended the deceased from 7-12-67 , 19 67 , to 8-21-67 , 19 67 , that (I) (we) last saw the deceased alive on 8-21-67 , 19 67 , and that death occurred at 6:10 AM M, from causes and on the date stated above									
22a. SIGNATURE <i>Agustin del Campo.</i>				22b. DATE SIGNED 8-21-67					
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-23-67	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Brair Cemetery	23d. LOCATION (City or Town) Keedysville Rfd. 1, Md.		(County) (State)			
24. FUNERAL DIRECTOR John H. Bost, Jr.		ADDRESS BOST Funeral Home, 112 N. Main St. Boonsboro, Md.		25a. REC'D. BY REGISTRAR AUG 25 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

10865

10865

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Manchester, Md

c. LENGTH OF STAY IN 1b

2 mos

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

201 York St

**3. NAME OF
DECEASED
(Type or print)**

First *E*

Middle *Stella*

Last *Grace*

4. DATE
OF
DEATH

Month *Aug*

Day *24*

Year *1967*

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Aug 16 1891

9. AGE (In years
last birthday)

76 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

N/A

11. BIRTHPLACE (County & State, or foreign country)

Carroll Co., Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Adam Froidinger

14. MOTHER'S MAIDEN NAME

Mary Yingling

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-36-3943

17. INFORMANT

Mrs Mary Dwyer

Manchester, Md

INTERVAL BETWEEN
ONSET AND DEATH

1 year

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

180X

DUE TO

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

*Renal Carcinoma left
kidney*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. *19* Not White at work at work

20d. INJURY OCCURRED While at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) *Manchester*

(County) *Carroll Co.*

(State) *Md.*

21. I certify that (I) (this hospital) attended the deceased from *1966*, to *Aug 24, 1967*, that (I) (we) last saw the deceased alive on *Aug 22, 1967*, and that death occurred at *1040 Carroll Rd.* My from the causes and on the date stated above.

22a. SIGNATURE

W.H. Board

22b. DATE SIGNED

8/24/67

22c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS
W.H. Board M.D. Manchester, Md. 21102

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

Burial

Aug. 27, 1967

Manchester Cemetery

Manchester Carroll Co. Md.

24. FUNERAL DIRECTOR

ADDRESS

Tipton - Eline Funeral Home Hampstead, Md.

25a. REC'D BY REGISTRAR

DATE

AUG 28 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

Local authority - your local government body is the Local
Authority. It has powers "to do anything" which - except

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10866

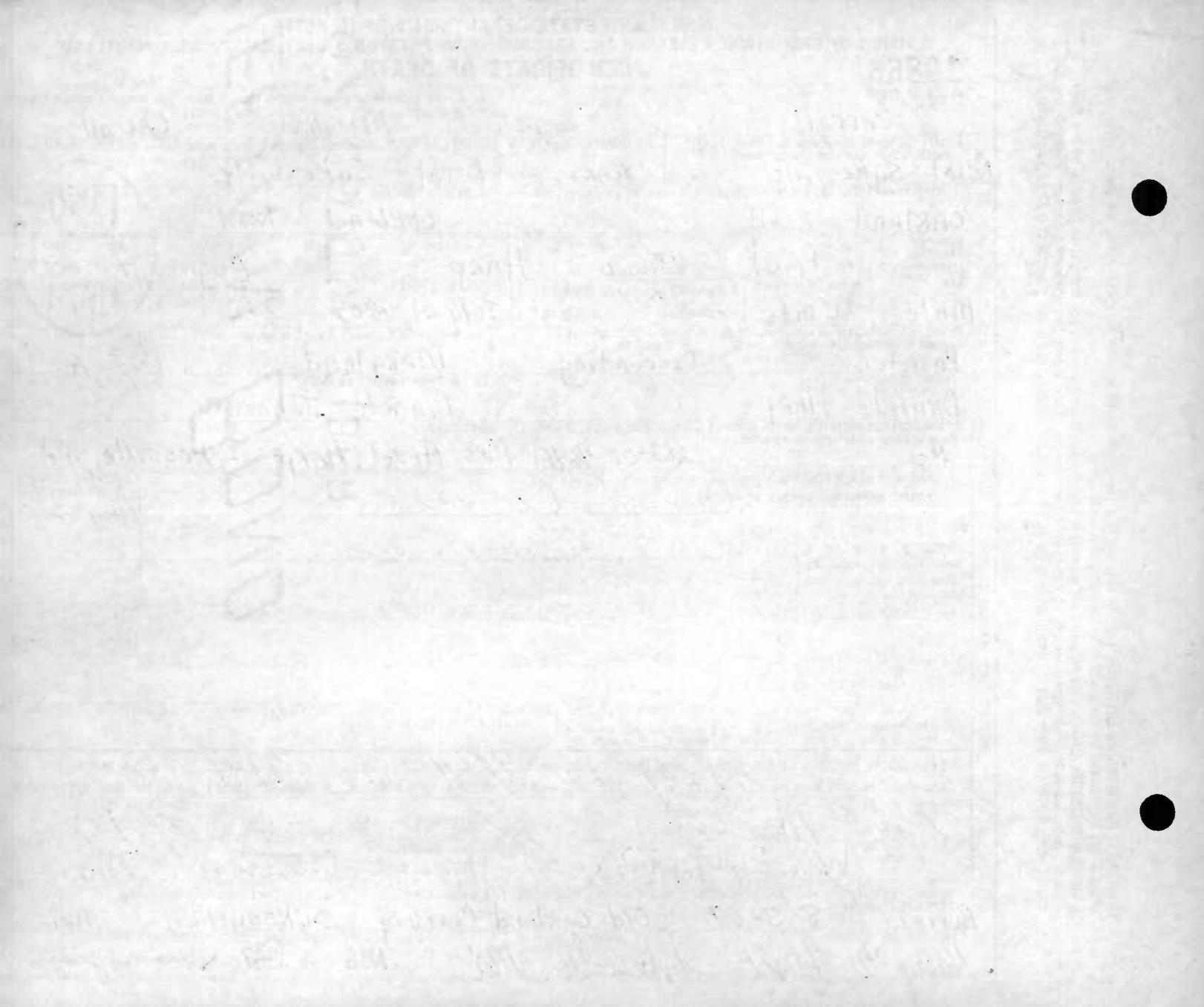
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Sykesville		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Sykesville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) OAKLAND Road		d. STREET ADDRESS OAKLAND Road		4. DATE OF DEATH Aug. 1 1967		Month Day Year	
3. NAME OF DECEASED (Type or print) Paul		First Jacob	Middle HARP	Last HARP	Month Aug.	Day 1	Year 1967
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1907	9. AGE (in years, last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Decorating		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel HARP		14. MOTHER'S MADDEN NAME Blanch Johnson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-01-4646	
17. INFORMANT Mrs. Hazel HARP - Sykesville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)-] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the cause (a), stating the underlying cause last. (b) Arteriosclerosis (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Address 74 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Randallstown	20f. (City or town) Sykesville	(County) Md.	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 1964 , 19, to 1967 , 19, that (I) (we) last saw the deceased alive on 7/29/1967 , and that death occurred at 54 , M, from the causes and on the date stated above.		22b. DATE SIGNED 5/2/68					
22a. SIGNATURE Wm. E. Martin		22b. DATE SIGNED 5/2/68					
22c. PHYSICIAN'S NAME (Type) Wm. E. MARTIN		22d. ADDRESS Randallstown					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-3-67	23c. NAME OF CEMETERY OR CREMATORIAL Old Oakland Cemetery	23d. LOCATION (City, town or county) Sykesville			(State) Md.
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.	25a. REC'D BY REGISTRAR Charles J. George		25b. REGISTRAR'S SIGNATURE Charles J. George		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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10867

CERTIFICATE OF DEATH

10867

1. PLACE OF DEATH a. COUNTY Carroll			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville			c. LENGTH OF STAY IN 1b 12y. 10m. 21d.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. STREET ADDRESS 23 Winter Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Bertha	Middle Mae	Last Harris	4. DATE OF DEATH Month 8	Year 22 1967
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/5/19	9. AGE (In years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME John Cleggett Harris			14. MOTHER'S MAIDEN NAME Edna Mae Boward		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PSEUDOMONAS DUE TO CHRONIC PYELONEPHRITIS INTERVAL BETWEEN ONSET AND DEATH days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC PYELONEPHRITIS (c) Chronic					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Schizophrenic reaction, chronic undifferentiated type.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from 10/1/54 , 19 67 , to 8/22/1967 , that (he) (we) last saw the deceased alive on 8/22/1967 , and that death occurred at 12:50 P.M. from causes and on the date stated above.					
22o. SIGNATURE Renato R. Espina					
22c. PHYSICIAN'S NAME (Type) Renato R. Espina, M. D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/22/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/67		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	
24. FUNERAL DIRECTOR Charles J. Spina, Jr.		ADDRESS Best Haven Funeral Chapel - Hagerstown, Md.		23d. LOCATION (City or Town) (County) (State) Hagerstown Washington Md.	
25a. REC'D BY REGISTRAR DATE AUG 24 1967		25b. REGISTRAR'S SIGNATURE Charles J. Spina			

12/25/3

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10868

CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND		b. COUNTY BALTO. CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN lb 38 yrs. 8 da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALBERTON, MARYLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		031	
3. NAME OF DECEASED (Type or print)	First LUTHER	Middle NMN	Last HIGGS	4. DATE OF DEATH	Month 8	Doy 9	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/24/97	9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Higgs		14. MOTHER'S MAIDEN NAME Barbara Payner		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6884-T		17. INFORMANT Springfield State Hosp. Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 Congestive failure.				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost.		DUE TO 4341					
DUE TO 4341		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental Deficiency				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-17-1967 , to 8-9-1967 , that (I) (we) last saw the deceased alive on 8-9-1967 , and that death occurred at 2 p.m., from causes and on the date stated above.							
22a. SIGNATURE Orlando C. Ramos		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/9/67			
22c. PHYSICIAN'S NAME (Type) Orlando C. Ramos		22d. ADDRESS Springfield State Hospital, Sykesville Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-67		23c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd		23d. LOCATION (City or Town) (County) (State) Ellicott City, Md.	
24. FUNERAL DIRECTOR Kerry Haight		ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE AUG 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10869

CERTIFICATE OF DEATH

10869

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb lyr. 3 mos. 6 dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Finksburg		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First ALVERTA	Middle ELIZABETH	Last HILL	4. DATE OF DEATH	Month August	Day 4	Year 19 67
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-19	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Dayton Waltz				14. MOTHER'S MAIDEN NAME Julia Wagner Shipley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Records, Springfield State Hospital		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of Left Breast with Metastases						INTERVAL BETWEEN ONSET AND DEATH Months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170X		DUE TO (b) _____	DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, chronic undifferentiated type						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 4-28-66 , 18, to 8-4-67 , 19, that (I) (we) last saw the deceased alive on 8-4-67 , 19, and that death occurred at 2:35 PM , from causes and on the date stated above.				22b. DATE SIGNED 8-4-67				
22a. SIGNATURE Dr. Antonius Glahn		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/67	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cemetery, Carroll, Md.	23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.		ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE				
			DATE AUG 8 1967					

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18281

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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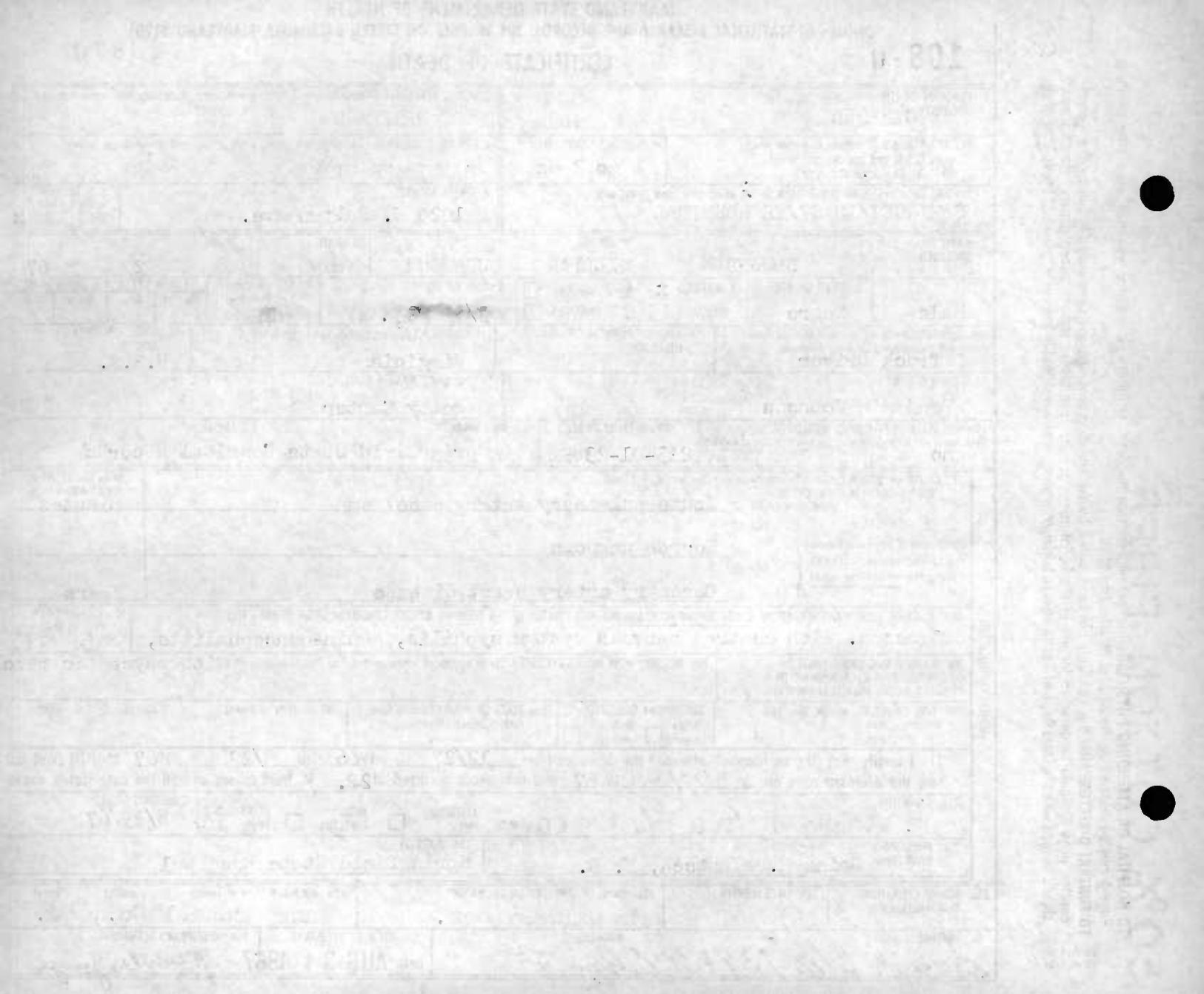
10870

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN lb 8 mo 2 da	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL			d. STREET ADDRESS 1020 N. Fulton Ave.		20 4
3. NAME OF DECEASED (Type or print) EDWARD WILLIAM JOHNSON			4. DATE OF DEATH 8 29 19 67	Month Day Year	
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 15, 1903	9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Benjamin Johnson			14. MOTHER'S MAIDEN NAME Betty Carter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-01-2389		17. INFORMANT /Springfield State Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary artery embolism</u> INTERVAL BETWEEN ONSET AND DEATH MINUTES 4201					
DUE TO (b) <u>Source unknown</u>					
DUE TO (c) <u>Coronary artery heart disease</u> YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with central nervous system syphilis, meningoencephalitis,					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) With psychotic reaction			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/27, 1966, to 8/29, 1967, that (I) (we) last saw the deceased alive on 8/29, 1967, and that death occurred at 2P.M., from causes and on the date stated above.					
22a. SIGNATURE <u>Heinz H. Klaatsch MD</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 8/29/67					
22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D. 22d. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/2/67	23c. NAME OF CEMETERY OR CREMATORIAL Mt Calvary Cem.		23d. LOCATION (City or Town) (County) (State) Anne Arundel Co., Md.
24. FUNERAL DIRECTOR <u>George A. Kelen</u>			ADDRESS 1348 N. Calvert St	25a. REC'D BY REGISTRAR DATE AUG 31 1967	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. Geiger</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

10871

CERTIFICATE OF DEATH

10871

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 7		d. STREET ADDRESS Route # 7	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Annie	Middle Charity	Last Keefer
4. DATE OF DEATH	Month August	Year 1967	Doy 21
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 1, 1879		9. AGE (In years lost birthday) 88 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Taneytown, Maryland	
13. FATHER'S NAME Benjamin Fleagle		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Martha Jane Harner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 215-36-8052		17. INFORMANT Address Mr. Melvin Keefer, R # 7, Westminster, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 331x DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		INTERVAL BETWEEN ONSET AND DEATH about 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. Aug 24, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mayberry Cemetery
20f. (City or town) R # 7 Westminster, Car. Md.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 21, 1967 , to Aug 21, 1967 , that (I) (we) last saw the deceased alive on Aug 21, 1967 , and that death occurred at Mayberry Cemetery , M, from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE E. Reese Wilkens		22b. DATE SIGNED Aug 24, 1967	
22c. PHYSICIAN'S NAME (Type) E. Reese Wilkens		22d. ADDRESS 15 Kemper Ave., Westminster, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 24, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mayberry Cemetery		23d. LOCATION (City or Town) (County) (State) R # 7 Westminster, Car. Md.	
24. FUNERAL DIRECTOR C.O. Fuss & Son		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 24 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10873

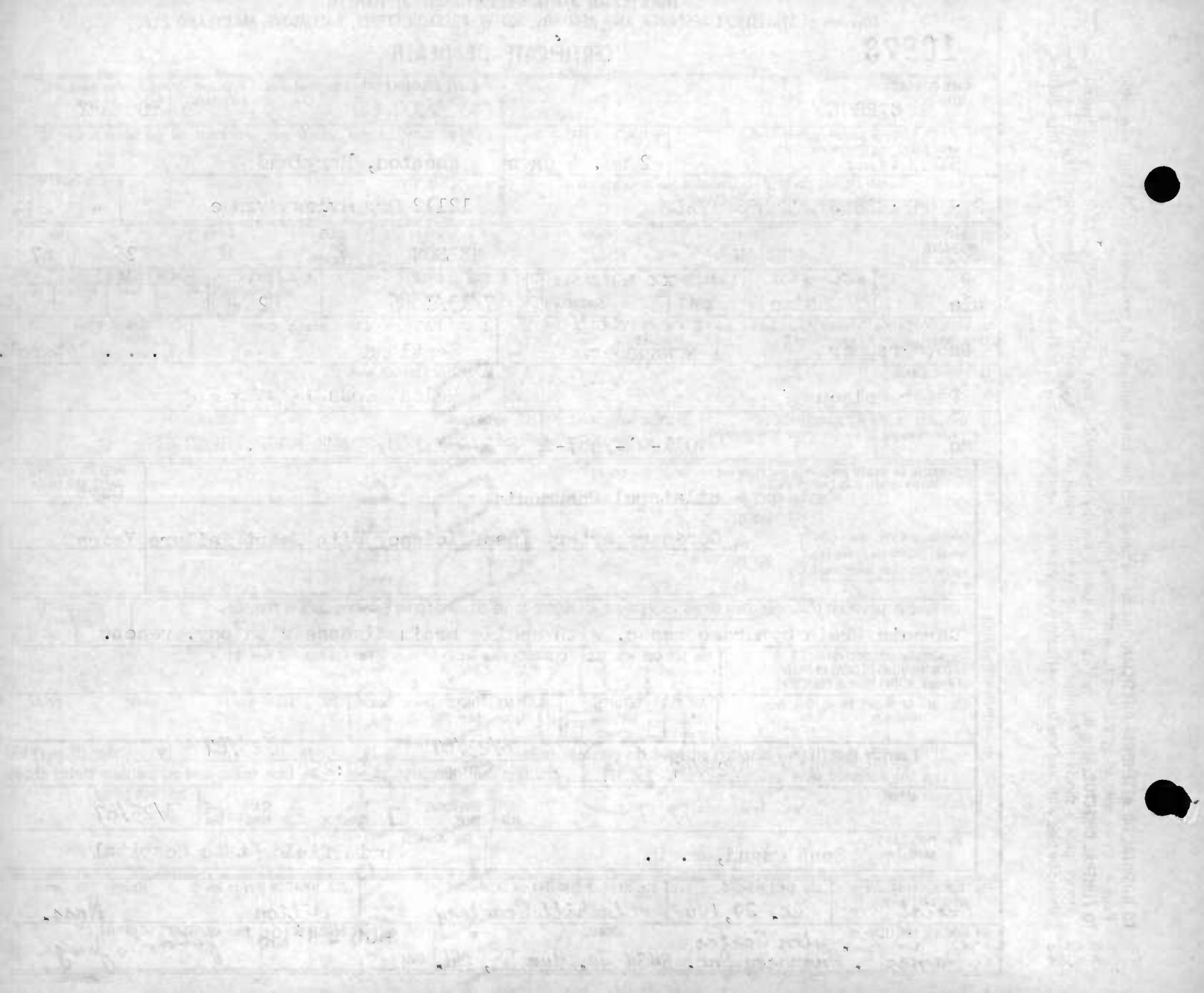
CERTIFICATE OF DEATH

10873

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN lb 2 mo. 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL				d. STREET ADDRESS 12112 Grandview Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBSON		First NMN	Middle NELSON	4. DATE OF DEATH 8	Month 8	Day 25	Year 19 67
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/1885	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (County & State, or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A. Natural	
13. FATHER'S NAME Peter Nelson				14. MOTHER'S MAIDEN NAME Helen Ross WALKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 011-01-9487-A		17. INFORMANT SPRINGFIELD STATE HOSP. RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia INTERVAL BETWEEN ONSET AND DEATH Days 4201							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Insufficiency With Heart Failure Years							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Chronic Brain Syndrome assoc. with senile brain disease with psy. reactivities <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION		19. WAS AUTOPSY PERFORMED?					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/23/67 , 19 to 8/25/67 , 19, that (I) (we) last saw the deceased alive on 8/25/67 , 19, and that death occurred at 10:25 AM , from causes and on the date stated above.							
22o. SIGNATURE Suha Ozgun.		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D.		22d. ADDRESS Springfield State Hospital					
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 29, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Bluehill Cemetery		23d. LOCATION (City or Town) (County) (State) Milton Mass.	
24. FUNERAL DIRECTOR Glen Carter Warren E. Pumphrey Inc.		ADDRESS 8434 Ga. Ave SS, Md.		25o. REG'D BY REGISTRAR AUG 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10876

10876

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER RD#4		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) REESE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER RD#4	
d. STREET ADDRESS REESE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EMMA	Middle T.	Last NICKOLES
4. DATE OF DEATH Month AUG. 3	Month 1967	Day 06.1	Year
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9 1877
9. AGE (In years last birthday) 90 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE	11. BIRTHPLACE (County & State or foreign country) CARROLL CO. MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ?	14. MOTHER'S MAIDEN NAME HEISER	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —	
16. SOCIAL SECURITY NO. 212-50-3178-1		17. INFORMANT MRS. LEONA E. WILHELM,	Address UPPERCO MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart disease Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Congestive heart failure DUE TO (c) Atherosclerosis General Moderate Hypertension			
INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3-5 yrs			
3-5 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-28-67 to 8-3 , 1967, that (I) (we) last saw the deceased alive on 8-1-67 1967, and that death occurred at 7-31-67 on the causes and on the date stated above.		22b. DATE SIGNED 8-4-67	
22a. SIGNATURE Alleene Speckler		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) J. S. Myers, Jr., Westminster, Md.		22d. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/16/67	23c. NAME OF CEMETERY OR CREMATORIAL MT. PLEASANT CEM. GAMBER Carroll Co. MD	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
DATE AUG 8 1967			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

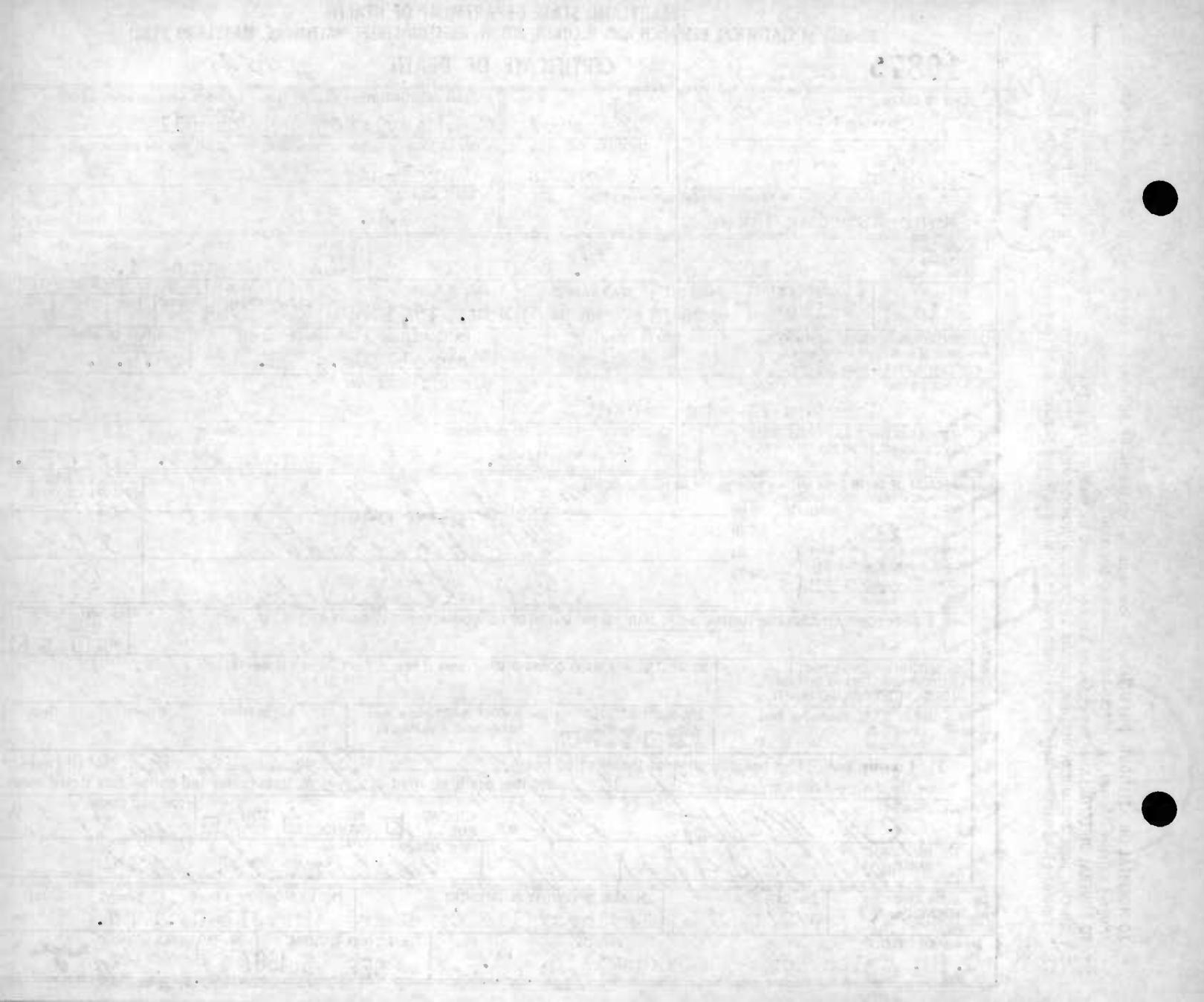
10875

CERTIFICATE OF DEATH

10875

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gist		c. LENGTH OF STAY IN lb 2 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westminster 06-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 90 Ross Nursing Home				d. STREET ADDRESS R.D. 5			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First ROY	Middle E.	Lost	4. DATE OF DEATH	Month August 31,	Day 19 Year 67
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 15, 1889	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Eugene Pickett				14. MOTHER'S MAIDEN NAME Verdie Harn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs. Ruby Logue R.D. 2 Mt. Airy, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 14221 DUE TO _____ Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH 9 days 2 fm 2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 2				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>67</u> , to <u>Aug 31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 31</u> , 19 <u>67</u> , and that death occurred on <u>Aug 31</u> , 19 <u>67</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>H. J. Waltz</u>				22b. DATE SIGNED <u>Aug 31-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>MAJ TIN MP</u>		22d. ADDRESS <u>Rural-Westminster</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/1967		23c. NAME OF CEMETERY OR CREMATORIAL Taylorsville Cemetery		23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.				ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/66				DATE SEP 5 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 10876 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Item 8 Film G392 8/24/67

10876

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 2 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8323 Wyton Road. Balto. Co. 0312	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Grandview Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Catherine	Middle Mary	Last PRINDEZE
4. DATE OF DEATH 8 17 1967	Month Day Year	Month Day Year	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/92 AGE (In years last birthday) 8/17/67/ 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State, or foreign country) Greece	12. CITIZEN OF WHAT COUNTRY? Greece
13. FATHER'S NAME Nicholas Roussos	14. MOTHER'S MAIDEN NAME Mary Roussos		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 216 01 9812	17. INFORMANT Jos. N. Prindeze	Address 8323 Wyton Rd. Balto. Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease			
443X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis			
DUE TO (c) Advanced Senile Changes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 25/Feb/65 , 19_____, to 17/Aug/67 , 19_____, that (I) (we) last saw the deceased alive on 16/Aug/67 , 19_____, and that death occurred at 10:51 AM from the causes and on the date stated above.			
22a. SIGNATURE <i>H. Lawson</i>		22b. DATE SIGNED 17/Aug/67	
22c. PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Box 54, RD #2, Sykesville, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-19-67	23c. NAME OF CEMETERY OR CREMATORIAL Most Holy Redeemer	23d. LOCATION (City, town or county) (State) Balto. Maryland.
24. FUNERAL DIRECTOR Wm. E. Johnson	ADDRESS 8521 Loch Raven Blvd. Balto. Md.	25a. REC'D BY REGISTRAR AUG 21 1967	25b. REGISTRAR'S SIGNATURE <i>John J. ...</i>

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19877

CERTIFICATE OF DEATH

10877

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Cornelia Pritchett</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	c. LENGTH OF STAY IN lb <i>70</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holiday Inn Hotel Home</i>		d. STREET ADDRESS <i>4525 Arabia Ave.</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Cornelia Mae Mary Pritchett</i>	Middle <i>Mae Mary</i>	Last <i>Pritchett</i>			
S. SEX Female	6. CBLDR DR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDWED <input type="checkbox"/> DIVDRCD	8. DATE OF BIRTH June 7, 1875.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Theodore Stewart	14. MOTHER'S MAIDEN NAME Margaret Heath					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 218-52-1324	17. INFORMANT Mr. J. Clinton Pritchett, Lutherville, Md.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Bronchitis Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Chronic Myocarditis</i>		INTERVAL BETWEEN DISEASE AND DEATH <i>8 weeks</i>				
DUE TO (b) <i>Chronic Myocarditis</i> DUE TO (c) <i>Lung Adeno Sclerosis</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Aug 14		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.)	20f. (City or town) Baltimore	(County) Md.	(State)
21. I certify that (I) (this hospital) attended the deceased from Aug 3, 1967 , to Aug 14, 1967 , that (I) (we) last saw the deceased alive on Aug 14, 1967 , and that death occurred at Baltimore M., from causes and on the date stated above.				22b. DATE SIGNED Aug 14-67		
22a. SIGNATURE <i>M. M. Martin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>M. M. Martin</i>		22d. ADDRESS <i>Westminster Ave</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/17/67.	23c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery	23d. LOCATION (City or Town) Baltimore, Md.	(County)	(State)
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	25a. REC'D BY REGISTRAR AUG 15 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

100

booklets

unclassified

DOA header 2004

ABU

header

other documents

business records

all items listed heretofore remain 100% DOA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, **page 3**, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10878

CERTIFICATE OF DEATH

10878

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Middleburg Md.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Brookfield Manor Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Ethel B. Rife

4. DATE
OF
DEATH

Aug 10,

Month Day Year
19 67

5. SEX

Female

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

DIVORCED

B. DATE OF BIRTH

May 17, 1891

9. AGE (in years
less birthday
yrs.)

76

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Brown

14. MOTHER'S MAIDEN NAME

Annie Crickenberger

Address

Same

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

212-46-5355

17. INFORMANT

Mr. David Rife

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

4221

DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Arteriosclerotic C.V.D.

INTERVAL BETWEEN
ONSET AND DEATH

years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. 19
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from..... 8/10/67, 19..... to 8/10/67, 19....., that (I) (we) last saw the deceased alive on..... 8/6/67, 19....., and that death occurred at 90th St. M., from the causes and on the date stated above.

22e. SIGNATURE

M. E. Robertson

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

8/10/67

22c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS

New Windsor, Md

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

8/14/67

23c. NAME OF CEMETERY OR CREMATORIAL

Woodlawn Cemetery

23d. LOCATION (City, town or county)

Baltimore Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Leonard J. Ruck Inc.

ADDRESS

5305 Harford Rd.

25a. REC'D BY REGISTRAR

AUG 15 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

BR -
VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10879

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10879

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge RD		c. LENGTH OF STAY IN lb 3 years		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge RD		b. COUNTY Carroll	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Horton Boarding Home				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) MARY		First	Middle	Last	4. DATE OF DEATH 8 - 26	Month	Day Year 1967
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 14-1887	9. AGE (In years, last birthday) 80	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Augustus McClelland				14. MOTHER'S MAIDEN NAME Gusta Ellen Strine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs. Charles B. Thomas, Linwood, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerotic heart disease 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) decompensation (c) arterio sclerosis cerebral							
INTERVAL BETWEEN ONSET AND DEATH several yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. L. Speicher M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) 1855 West Street, Baltimore, Md.							
22. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8/29/67		23c. NAME OF CEMETERY OR CREMATORIUM Stone Chapel		23d. LOCATION (City or Town) (County) (State) rural Westminster	
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.				ADDRESS		25a. REG'D BY REGISTRAR AUG 29 1967	25b. REGISTRAR'S SIGNATURE James Judge
VR A15ME (5) 6M 1/66							

“Lorinac”

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10880

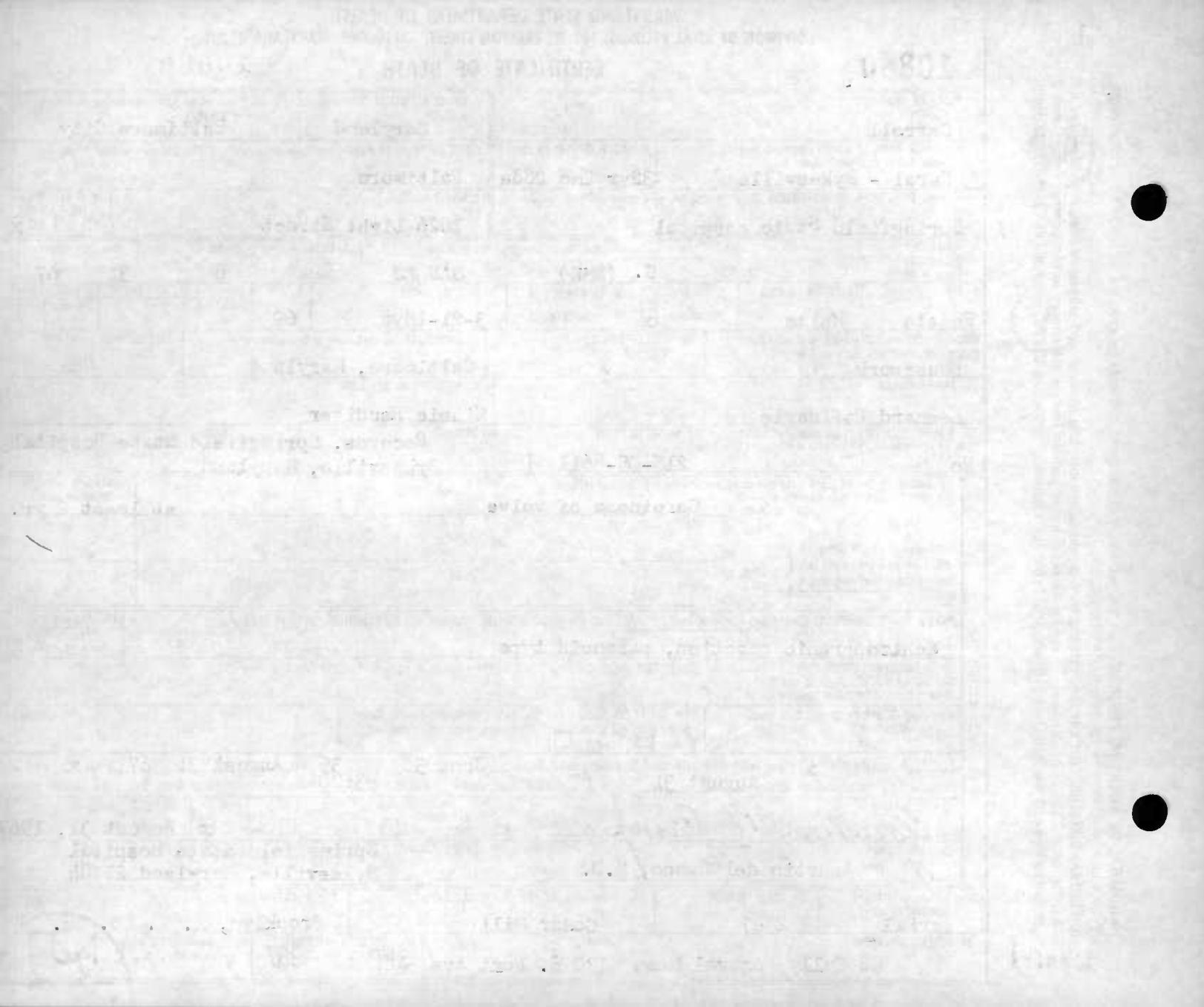
CERTIFICATE OF DEATH

10880

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		b. COUNTY Baltimore City	
c. LENGTH OF STAY IN lb 32yr 2mo 28da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1826 Light Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROSE C. (NMN)		First	Middle
4. DATE OF DEATH 8 31 1967	Last	Month	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-21-1898	9. AGE (In years lost birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Leonard Hoffnagle		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-8611	17. INFORMANT Records, Springfield State Hospital Address Sykesville, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Carcinoma of vulva		INTERVAL BETWEEN ONSET AND DEATH at least 2 yr.	
1760 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Schizophrenic reaction, paranoid type			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Brooklyn (County) A. A. Co. Md. (State)			
21. I certify that Agustin del Campo attended the deceased from June 3, 1935 , to August 31, 1967 , that we last saw the deceased alive on August 31, 1967 , and that death occurred at 3:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED August 31, 1967
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9 2 67	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill
23d. LOCATION (City or Town) (County) (State) Brooklyn, A. A. Co. Md.		23e. REG'D BY REGISTRAR DATE SEP 1 1967	
24. FUNERAL DIRECTOR Mc Cully Funeral Home		ADDRESS 130 E. Fort Ave	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

10881

CERTIFICATE OF DEATH

10881

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER RD #5		c. LENGTH OF STAY IN 1b 2 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WARFIELDSBURG ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EMMA	Middle RUTH	Last SHETTLE
4. DATE OF DEATH Month AUG.	Month 16	Day 1967	Year
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 10, 1896
9. AGE (in years last birthday) 71 yrs.	10. KIND OF BUSINESS OR INDUSTRY HOUSE-WIFE ALSO CLOTHING FACTORY	11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN BROWN	14. MOTHER'S MAIDEN NAME ANNIE HELIBRIDGE	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 213-05-3777		17. INFORMANT DEAN BROWN, TANEYTOWN, MD.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis (debr.) Hypertension (debr.)			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. 260X (b) Hypertension - (c) Diabetes (controlled) Clark Asthma			
INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jane 1940 to Aug 16-1967 , that (I) (we) last saw the deceased alive on Aug 15 1967 , and that death occurred at 545PM , from the causes and on the date stated above.			
22a. SIGNATURE W.C. JENNETH		22b. DATE SIGNED Aug. 17-67	
22c. PHYSICIAN'S NAME (Type) W.C. JENNETH		22d. ADDRESS 103 E Main Westminster MD 21157	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/19/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS PLEASANT VALLEY CEM. WESTMINSTER MD.
24. FUNERAL DIRECTOR J.S. Myers Jr., Westminster, Md.		25a. REC'D BY REGISTRAR AUG 21 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

1981.01.23
10.00-MILE WATERTOWER RD. GARDEN CITY ID.
WHITE MOUNTAIN SUMMIT ROAD
20 MIN. DRIVE
1000 FT. ELEVATION GAIN

Jeff. Stevenson

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

M

10882

CERTIFICATE OF DEATH

10882

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 40 yrs. +		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital			d. STREET ADDRESS 174 Willis Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) AUGUSTUS EARL		First S	Middle E	Lost H	4. DATE OF DEATH August 27 1967	Month August	Doy 27	Year 1967		
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-96		9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer			10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED			11. BIRTHPLACE (County & State, or foreign country) Hartford Co Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEXANDER SHIPLEY			14. MOTHER'S MAIDEN NAME EDITH MAY GEARY			Address SAME ADDRESS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.I.			16. SOCIAL SECURITY NO. 219-36-2029			17. INFORMANT MRS. GERTRUDE M. SHIPLEY				
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4200			DUE TO Arteriosclerotic Heart Disease							
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.			(b) DUE TO Arteriosclerotic Heart Disease							
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Westminster		(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 8-18 1967 , to 8-27 1967 , that (I) (we) last saw the deceased alive on 8-27 1967 , and that death occurred at 7:20 AM , from causes and on the date stated above.										
22a. SIGNATURE John S. Harshey			M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR			STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 8/27/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.			22d. ADDRESS 8 Anchor St. Westminster, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/30/67		23c. NAME OF CEMETERY OR CREMATORIAL Westminster Cemetery, Westminster, Md.		23d. LOCATION (City or Town) Westminster		(County) Md.	(State) Md.	
24. FUNERAL DIRECTOR J. S. Myers Jr., Westminster, Md.		ADDRESS		25a. REC'D. BY REGISTRAR AUG 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

RUDOLPH

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10883

10883

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 and 4 may be retained by the hospital or attending physician.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4mos. 12dys.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		d. STREET ADDRESS Dorsey Run Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN LOUISE SKEEL		First Middle Last	4. DATE OF DEATH Month AUGUST 9 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses' Aide		9. DATE OF BIRTH 12-1-1882	
10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Connecticut	
13. FATHER'S NAME Benjamin Paul Peck		14. MOTHER'S MAIDEN NAME Anna Eliza Hubbard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Address Records, Springfield State Hospital
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Cardiovascular renal disease INTERVAL BETWEEN ONSET AND DEATH YEARS 442X			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.		DUE TO (b)	
		DUE TO (c) Bronchopneumonia	Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cheshire, Conn.
21. I certify that (I) (this hospital) attended the deceased from 4-26-67 , 19 to 8-9-67 , 19, that (I) (we) last saw the deceased alive on 8-9-67 , 19, and that death occurred at 4:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Antonius Glahn		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 8-9-67
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-12-67	23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Church Cemetery
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.	25a. RECEIVED BY REGISTRAR DATE AUG 14 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

HOME TO STAMPEDE



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10884

10884

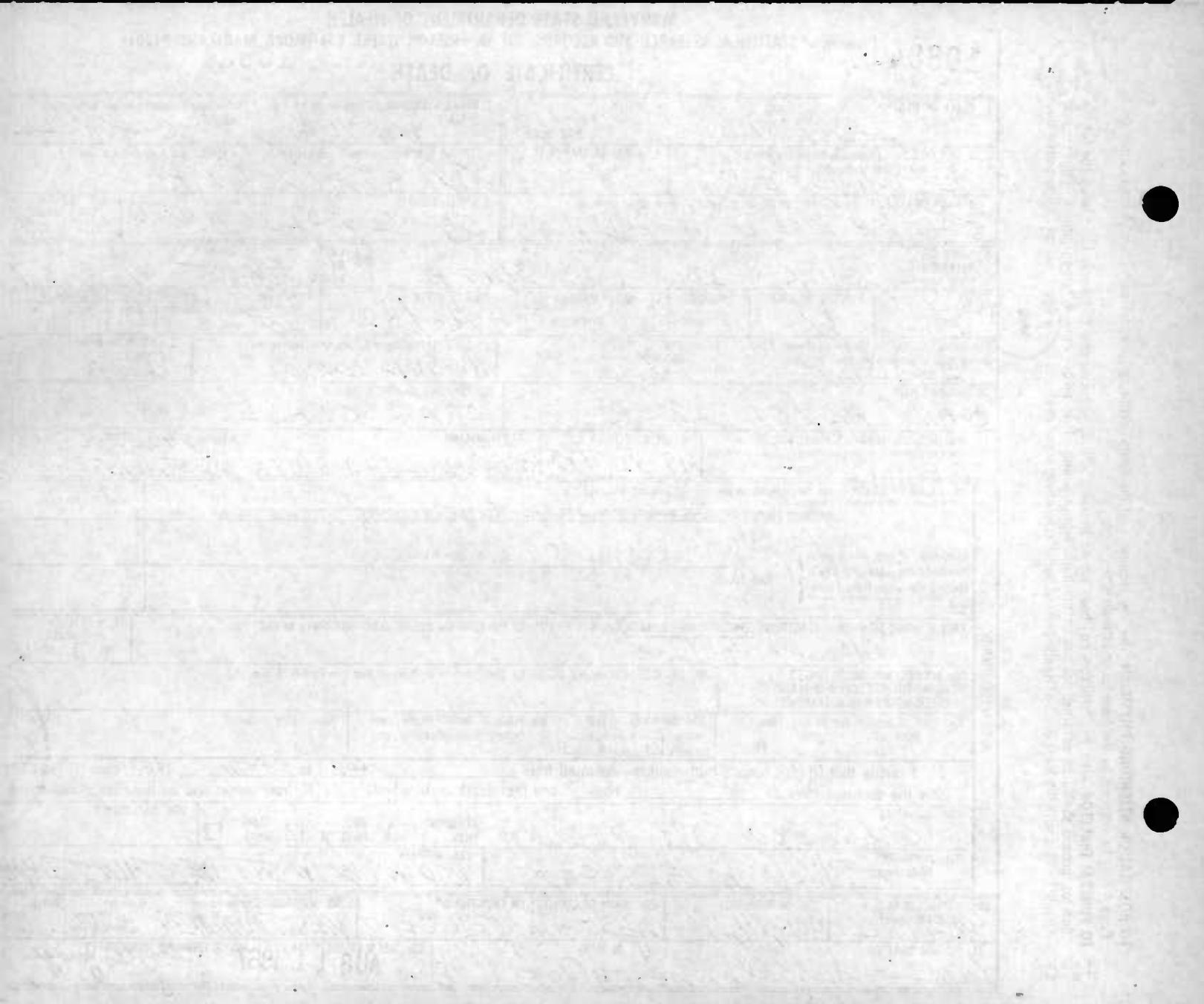
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		b. COUNTY CARROLL	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 54 BEZOLD ROAD		d. STREET ADDRESS 54 BEZOLD ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DELTA JO		First SMITH	Middle LAST
4. DATE OF DEATH Month AUGUST Day 11 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/32
9. AGE (In years last birthday) 35 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY HOME	12. BIRTHPLACE (County & State, or foreign country) KOOSKIA IDAHO,
13. FATHER'S NAME JOHN HAZEL BAKER	14. MOTHER'S MAIDEN NAME ORA CHASE	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 579-32-7563		17. INFORMANT HUSBAND-WILLIAM M. SMITH WESTMINSTER MD	Address 54 BEZOLD RD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO 154X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Rectal Carcinoma			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hepatic Failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1963 , to 8-11 , 1967, that (I) (we) lost saw the deceased alive on 8-7 1967, and that death occurred at 3:30 P.M. from causes and on the date stated above.			
22o. SIGNATURE Philip W. Mercer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) PHILIP W. MERCER		22d. ADDRESS 150 W. MAIN ST. WESTMINSTER MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF AUG 14, 1967	23c. NAME OF CEMETERY OR CREMATORIAL WESTMINSTER CEM.	23d. LOCATION (City or Town) (County) (State) WESTMINSTER, CARROLL MD
24. FUNERAL DIRECTOR James G. Saffell Jr.	254 ADDRESS E. MAIN	25o. RECD. BY REGISTRAR DATE Charles Judge AUG 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19885

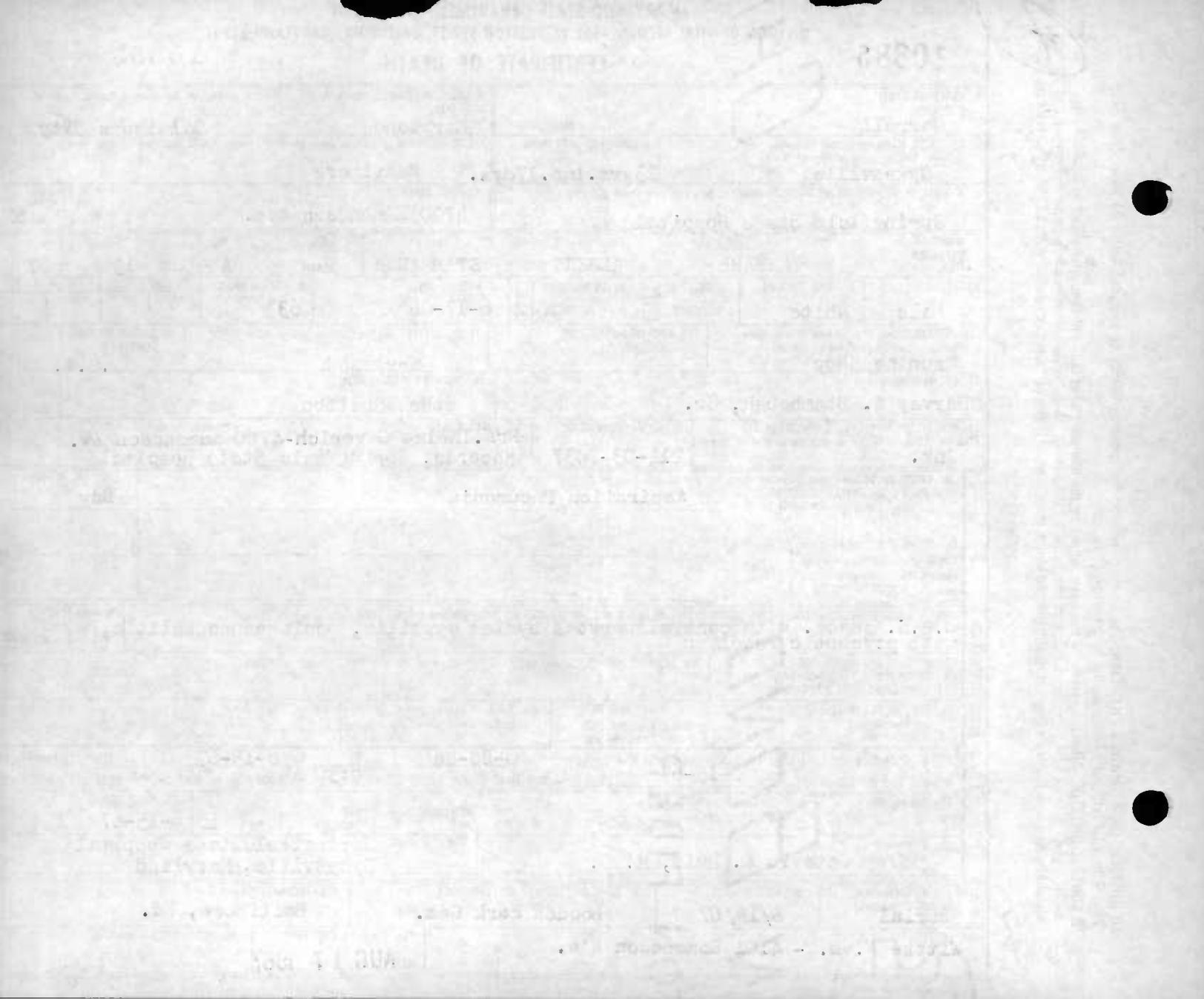
CERTIFICATE OF DEATH

10885

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1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 23 yrs. 1 mo. 17 dvs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 4700 Edmondson Ave.	
3. NAME OF DECEASED (Type or print) EARL		First ALBERT	Middle STAMBAUGH
4. DATE OF DEATH AUGUST 15 1967	Month AUGUST	Doy 15	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 6-17-04	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Shop	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Harvey A. Stambaugh, Sr.	14. MOTHER'S MAIDEN NAME Ethel Shelton	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.	16. SOCIAL SECURITY NO. 214-03-7037	17. INFORMANT Mrs. Melma Gaverick	Address 4700 Edmondson Av.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia			INTERVAL BETWEEN ONSET AND DEATH Day
DUE TO H91X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) C.B.S. assoc. with central nervous system syphilis, meningoencephalitis with psychotic reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-28-64 , 19 64 , to 8-15-67 , 19 67 , that (I) (we) last saw the deceased alive on 8-15-67 , 19 67 , and that death occurred at 8:30 AM from causes and on the date stated above.			
22a. SIGNATURE <i>Octavio A. Ruiz</i>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.	22d. ADDRESS Springfield State Hospital	22b. DATE SIGNED 8-15-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/18/67	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.	ADDRESS 4101 Edmondson Ave.	25a. REC'D BY REGISTRAR CHARLES JUDGE	25b. REGISTRAR'S SIGNATURE CHARLES JUDGE



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10886

CERTIFICATE OF DEATH

10886

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville - Rural</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>417 E. Main St.</u>	
3. NAME OF DECEASED (Type or print) <u>Grace F. (Nmn) Staub</u>		First <u>Grace</u>	Middle <u>F. (Nmn)</u>
4. DATE OF DEATH Month <u>8</u> Month <u>-</u> Day <u>27</u> Year <u>1967</u>	Lost <u>Staub</u>	5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-86</u>	9. AGE (In years lost birthday) <u>80 yrs.</u>	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>C-JOSHUA FRANTZ</u> <u>Grover Staub</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>314-16-0542</u>	17. INFORMANT <u>Springfield Records; Sykesville, Md</u>	Address <u></u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH WEEKS <u></u>	
DUE TO <u>490X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>			
(b) <u>Pneumonia with pleural effusion</u>		days <u></u>	
DUE TO <u></u>			
(c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-10</u> , 19 <u>67</u> , to <u>8-27</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>8-27</u> 19 <u>67</u> , and that death occurred at <u>9:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Olindo C. Ramos</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>8-27-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Olindo C. RAMOS</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-30-67</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>PLEASANT VALLEY Cemetery</u>
23d. LOCATION (City or Town) <u>CARROLL COUNTY MD</u>		(County) <u></u> (State) <u></u>	
24. FUNERAL DIRECTOR ADDRESS <u>Windsor</u>		25a. REC'D BY REGISTRAR <u>NEW</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Geage</u>
DATE <u>AUG 29 1967</u>			

ATTACH TO TAGLINE

AR801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10887

CERTIFICATE OF DEATH

10887

1. PLACE OF DEATH
a. COUNTY

CARROLL

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

WESTMINSTER

c. LENGTH OF STAY IN 1b

YEARS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

ROUTE 5

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

JAMES CLARENCE STAUB

Month

Day

Year

8 - 17 - 1967

4. SEX

5. SEX

6. COLOR OR RACE

MALE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

5-19-1888

9. AGE (In years
last birthday)

79

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

yrs.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR
INDUSTRY

FARMER - RETIRED

OWNER

11. BIRTHPLACE (County & State, or foreign country)

MARYLAND

12. CITIZEN OF WHAT
COUNTRY

U.S.

13. FATHER'S NAME

GEORGE R. STAUB

14. MOTHER'S MAIDEN NAME

MARY FINNEY ROCK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-36-8117

17. INFORMANT

GRACE S. STAUB, WESTMINSTER, MD.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443X

DOUE TO

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

(b)

DOUE TO

(c)

Arteriosclerotic Cardiovascular
disease

Hypertension

Stroke & Seizure Hemiplegia

INTERVAL BETWEEN
ONSET AND DEATH

Several days

several weeks

Yes

3 yrs +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 17, 1967, to Aug 17, 1967, that (I) (we) last
saw the deceased alive on August 16, 1967, and that death occurred at 7:00 AM, from the causes and on the date stated above.

22a. SIGNATURE

Alexander Speicher M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
8-17-67

22c. PHYSICIAN'S
NAME (Type)

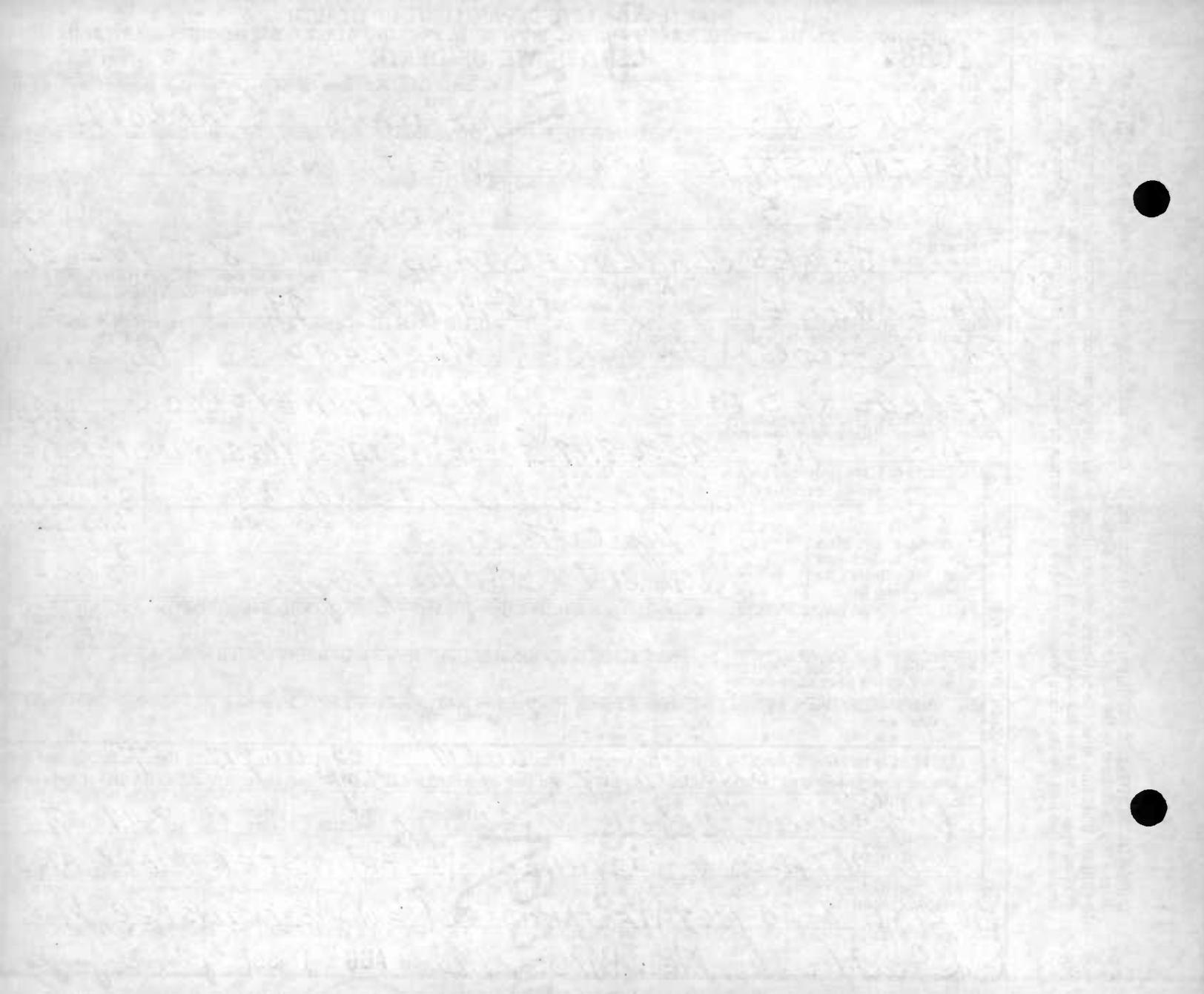
W. GLENN SPEICHER WESTMINSTER, MARYLAND

23a. BURIAL, CREMATION,
REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM 23d. LOCATION (City, town or county)
(State)

BURIAL 8-20-1967 WESTMINSTER Cem WESTMINSTER, MD.

24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

D. Hartnett & Sons NEW WINDSOR, MD. DATE AUG 21 1967 Charles Judge



1
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 90
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

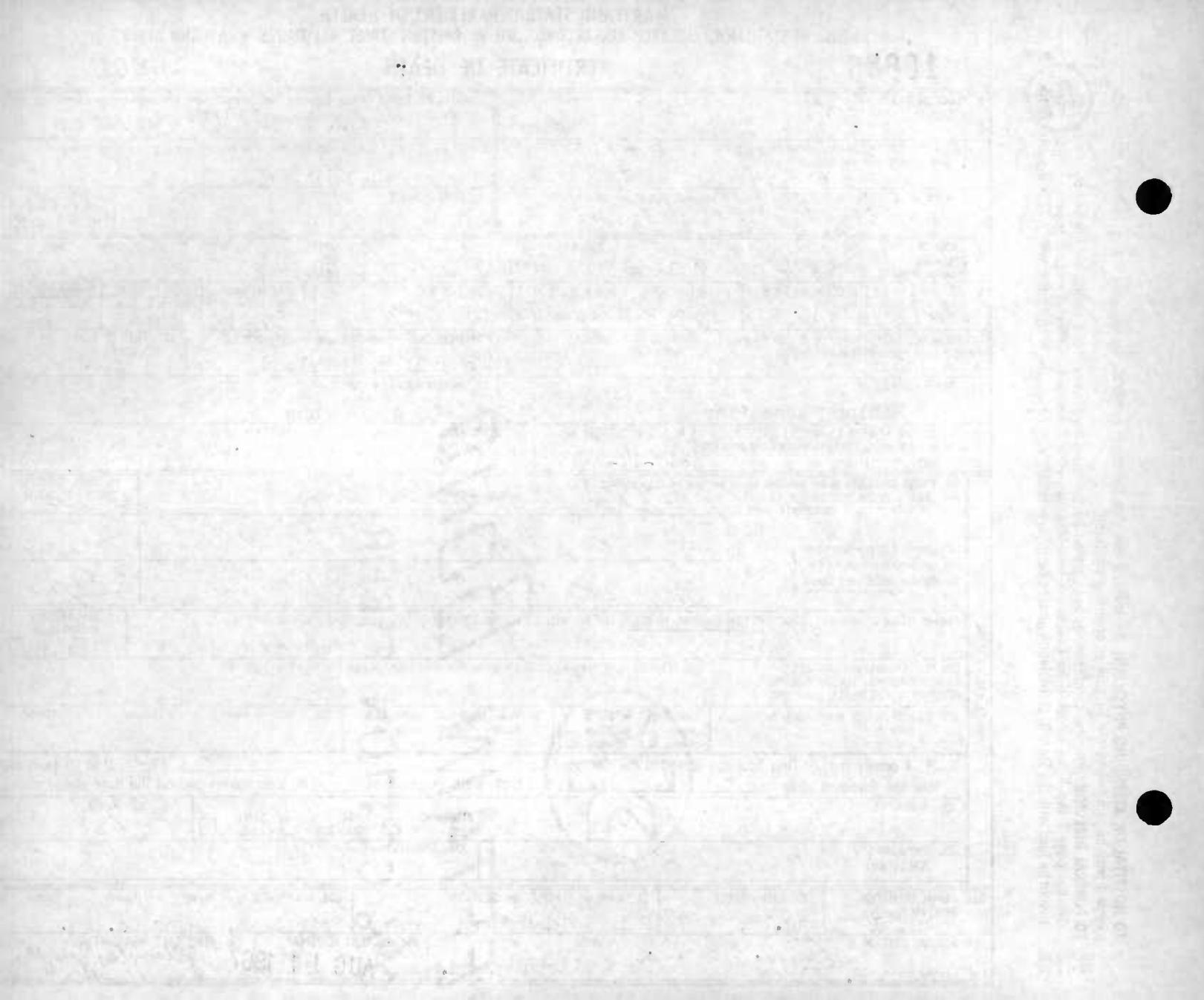
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10888

CERTIFICATE OF DEATH

10888

1. PLACE OF DEATH a. COUNTY <i>CARROLL</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>CARROLL</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SYRESVILLE</i> c. LENGTH OF STAY IN lb <i>8 DAYS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TANNEYTOWN</i> d. STREET ADDRESS <i>06-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pullen nursing home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robert William Stonesifer</i>		First <i>R</i> Middle <i>W</i> Lost <i>S</i>	4. DATE OF DEATH Month <i>8</i> Doy <i>10</i> Year <i>1967</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/19/96</i> 9. AGE (In years last birthday) <i>71</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Keysville, Maryland</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Mahlon Stonesifer</i>		14. MOTHER'S MAIDEN NAME <i>Annie Fuss</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-17-2448</i>	17. INFORMANT <i>MRS. TRUMAN HAHN - MEMORIAL PARK DR.</i> Address <i>TANNEYTOWN MD.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A. Coronary Occlusion</i> DUE TO <i>4201</i> INTERVAL BETWEEN ONSET AND DEATH <i>Budden</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>A. S. C. V.D</i> DUE TO <i>Generalized arteriosclerosis</i>		20 yrs 20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Multipe Rheumatoid Arthritis</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>8. 10. 1967</i> (County) <i>8. 10. 1967</i> (State) <i>8. 10. 1967</i>
21. I certify that <i>I</i> (this hospital) attended the deceased from <i>8. 10. 1967</i> to <i>8. 10. 1967</i> , that <i>I</i> (we) last saw the deceased alive on <i>8. 10. 1967</i> , and that death occurred at <i>8. 10. 1967</i> AM, from causes and on the date stated above		22b. DATE SIGNED <i>8. 10. 67</i>	
22a. SIGNATURE <i>Sami Okutman</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>8. 10. 67</i>
22c. PHYSICIAN'S NAME (Type) <i>Sami Okutman</i>		22d. ADDRESS <i>Sykesville, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 13, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIY <i>Fairfield Union Cemetery</i> 23d. LOCATION (City or Town) <i>Fairfield</i> (County) <i>Adams Co.</i> (State) <i>Pa.</i>
24. FUNERAL DIRECTOR <i>Clarence E. Wilson</i>		ADDRESS <i>Emmitsburg, Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
Clarence E. Wilson		DATE <i>AUG 14 1967</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

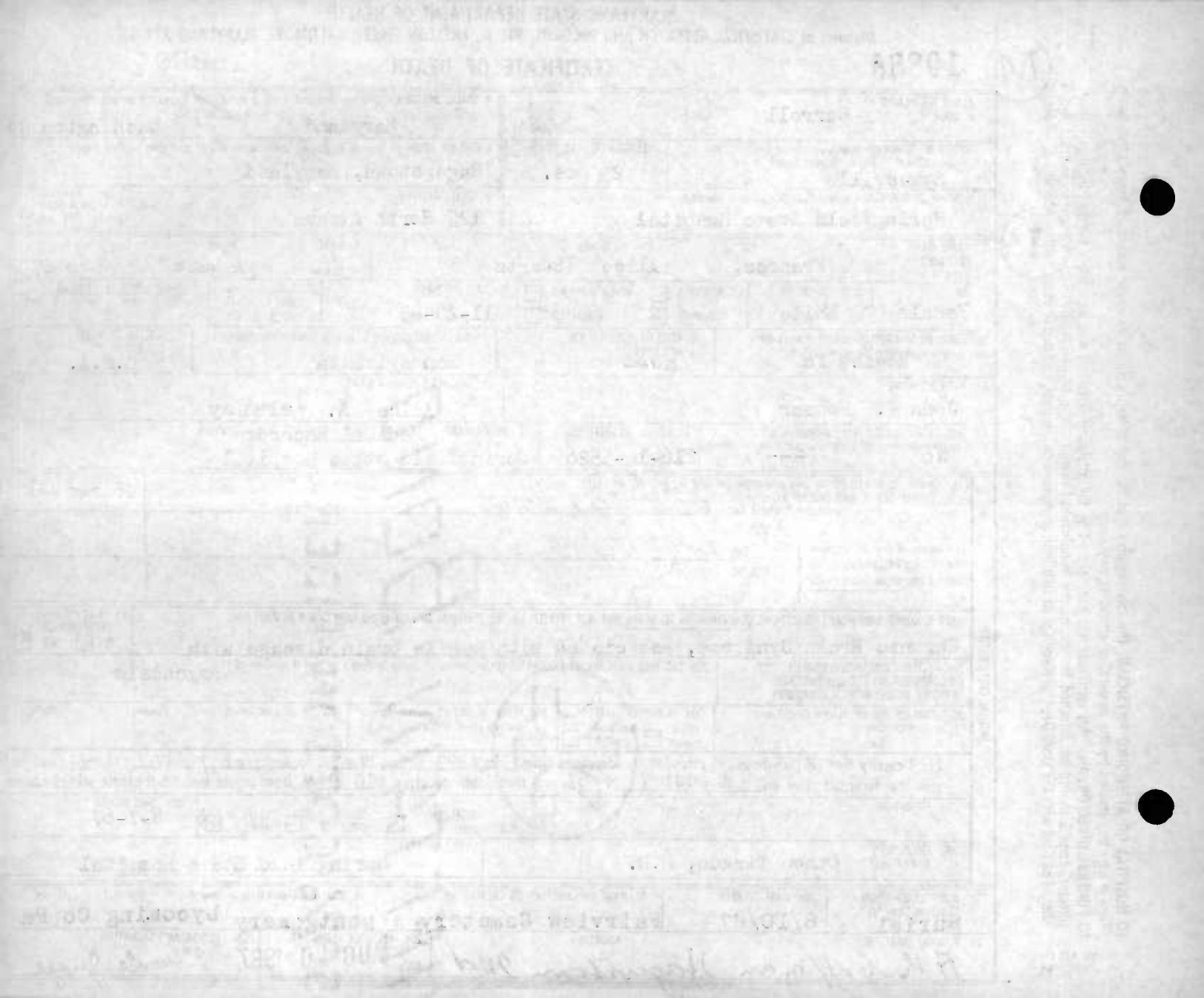
10889

CERTIFICATE OF DEATH

10889

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington Co						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2½ mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 125 North Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frances,	Middle Alice	Last Swartz	4. DATE OF DEATH	Month August	Doy 7	Year 1967		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-83	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Doy Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John T. Houser			14. MOTHER'S MAIDEN NAME Alice A. Delaney						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-14-5526		17. INFORMANT Medical Records Address Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Acute heart failure</u> 490X DUE TO (b) <u>acute pneumonia</u> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Chronic Brain Syndrome, associated with senile brain disease with psychosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) psychosis							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 23, 1967, to August 7, 1967, that (I) (we) last saw the deceased alive on August 7, 1967, and that death occurred at 10 P.M., from causes and on the date stated above.								22b. DATE SIGNED 8-7-67	
22a. SIGNATURE <u>Othon Tirado, M.D.</u>				22d. ADDRESS Springfield State Hospital					
22c. PHYSICIAN'S NAME (Type) Othon Tirado, M.D.				22d. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/10/67		23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery		23d. LOCATION (City or Town) (County) (State) Lycoming Co Pa			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H K Goffman Hagerstown Md				DATE AUG 10 1967		j Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10890

CERTIFICATE OF DEATH

10890

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN Tb 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 122 E. Baltimore Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Vira	Middle Elizabeth	Lost Taylor	4. DATE OF DEATH August 10	Month 1967	Doy Year
S. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-15-88	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during month of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Sewing		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George S. Williams			14. MOTHER'S MAIDEN NAME Anna Baker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-5981		17. INFORMANT Medical Records Address Springfield State Hospital, Sykesville		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO H201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary arteriosclerosis DUE TO lost (c)						INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic Brain Syndrome, associated with senile brain disease with psychotic reaction						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 8, 1966, to August 10, 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 10, 1967, and that death occurred at 7:45 AM, from causes and on the date stated above.						22b. DATE SIGNED 8-10-67
22a. SIGNATURE Sergio M. Palacio, M.D.			22b. DATE SIGNED 8-10-67			
22c. PHYSICIAN'S NAME (Type) Sergio M. Palacio, M.D.			22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-12-67		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery		23d. LOCATION (City, or Town) (County) (State) Pikesville, Baltimore, Md.
24. FUNERAL DIRECTOR Harry W. Haight ADDRESS Sykesville, Md.			25a. REC'D BY REGISTRAR AUG 14 1967			25b. REGISTRAR'S SIGNATURE Charles Judge
DATE						

MAILED TO 2140181912

1201

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

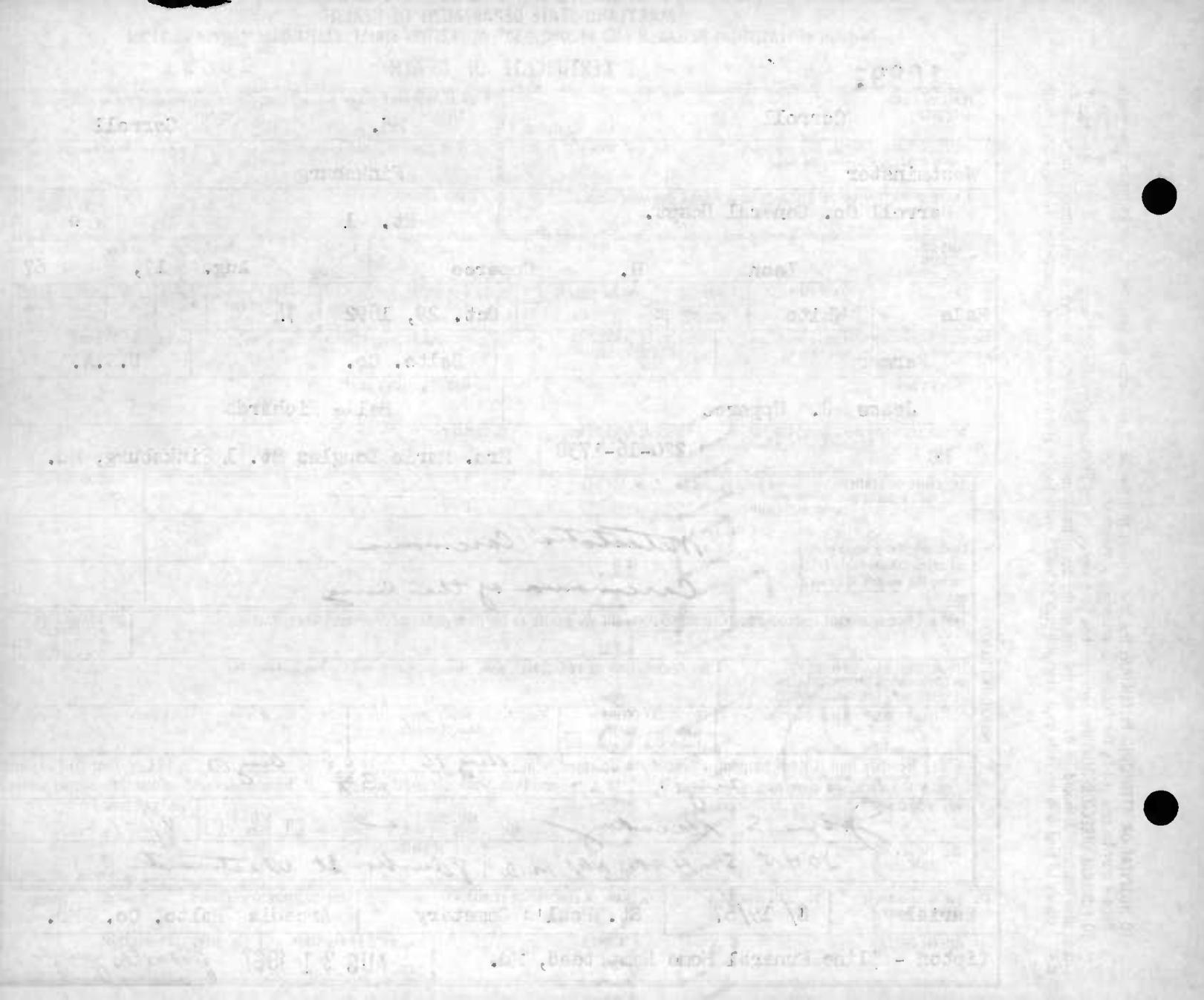
10891

CERTIFICATE OF DEATH

10891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hosp.			d. STREET ADDRESS Rt. 1		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Leon Middle R. Last Upperco				4. DATE OF DEATH Month Aug. 17, 1967 Day Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 29, 1892	9. AGE (In years 74 at birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Balto. Co.	
13. FATHER'S NAME Jesse J. Upperco			14. MOTHER'S MAIDEN NAME Belle Richards		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 220-16-1730		17. INFORMANT Address Mrs. Marie Douglas Rt. 1 Finksburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO <i>Metastatic Carcinous</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Carcinoma of the lung</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 16, 1967, to Aug 17, 1967, that (I) (we) last saw the deceased alive on Aug 17, 1967, and that death occurred at 3:30 M, from causes and on the date stated above.					
22a. SIGNATURE <i>John S. Harshey</i>		M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/17/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8th and Chestnut St. Westminster, Md.			
23a. BURIAL, CREMATION, BURNAWAY (Specify) Burial		23b. DATE THEREOF 8/19/67	23c. NAME OF CEMETERY OR CREMATORIALy St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Arcadia Balto. Co. Md.
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.			ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 21 1967
					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the attending physician. Page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10892

CERTIFICATE OF DEATH

10892

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 5 mos. 11 days Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield St. Hosp.		d. STREET ADDRESS 2412 Taney Road	
3. NAME OF DECEASED (Type or print) Milton (NMN)		First Weisberg	Middle
Last 		4. DATE OF DEATH Month August Day 28 Year 19 67	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY STATE DEPT. OF MD.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Human Weisberg		14. MOTHER'S MAIDEN NAME Rose Bass	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-9163 17. INFORMANT Springfield Hosp. Records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO 4201		INTERVAL BETWEEN ONSET AND DEATH Hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fibrosis of myocardium due to infarction DUE TO (c)		Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Schizophrenic reaction, chronic undifferentiated type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-17-67 , 19, to 8-28-67 , 19, that (I) (we) last saw the deceased alive on 8-28-67 , 19, and that death occurred on 8-28-67 , 19, at 2:40 P.M. from causes and on the date stated above			
22a. SIGNATURE <i>Octavio A. Ruiz</i>		22b. DATE SIGNED 8-28-67	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/28/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Anshe Emunah Aitz Chaim
24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
		25a. REC'D BY REGISTRAR DAT AUG 30 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

SUPPLY

RECEIVED FROM THE GOVERNMENT OF CANADA

FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

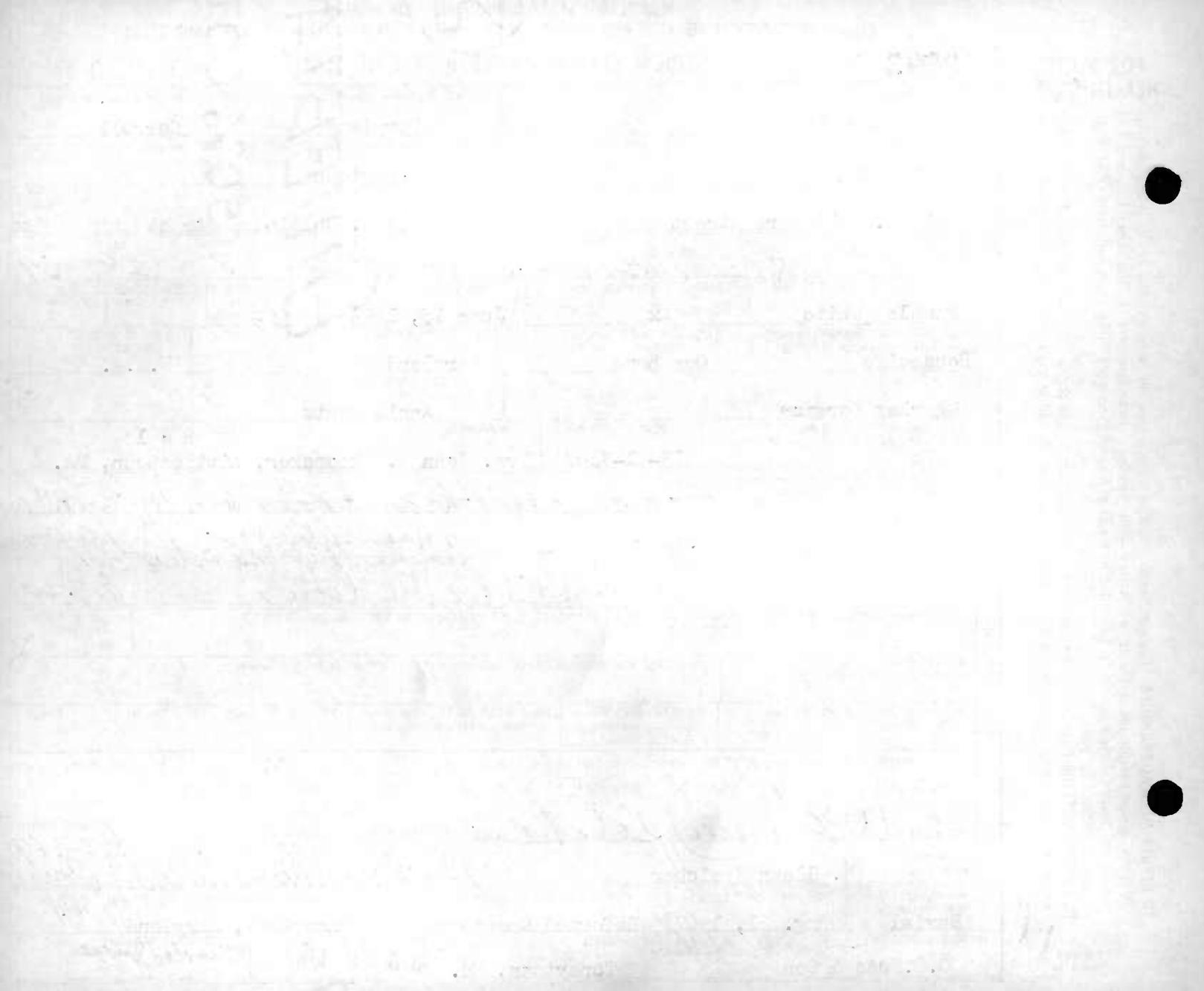
15ME (5)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10893

I. PLACE OF DEATH o. COUNTY Carroll				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland				b. COUNTY Carroll											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown				d. STREET ADDRESS 217 E. Baltimore Street											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 217 E. Baltimore Street								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) CARRIE VIRGINIA WEISCHAAR				First	Middle	Lost	4. DATE OF DEATH	Month	Doy	Year	8	28	1967										
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 15, 1894				9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. DAYS Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Charles Foreman				14. MOTHER'S MAIDEN NAME Annie Sentz																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No				16. SOCIAL SECURITY NO. 213-01-3167				17. INFORMANT Mrs. John R. Shoemaker, Littlestown, Pa.				Address R # 1											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { DUE TO (b) DUE TO (c) DUE TO (d) DUE TO (e) DUE TO (f) DUE TO (g) DUE TO (h) DUE TO (i) DUE TO (j) DUE TO (k) DUE TO (l) DUE TO (m) DUE TO (n) DUE TO (o) DUE TO (p) DUE TO (q) DUE TO (r) DUE TO (s) DUE TO (t) DUE TO (u) DUE TO (v) DUE TO (w) DUE TO (x) DUE TO (y) DUE TO (z) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				Coronary Thrombosis (acute) involving Hypertension & Cardiac Vasculitis Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 10 yrs 6 yrs															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <i>W. Glenn Speicher</i>				EXAMINER'S NAME (Type) W. Glenn Speicher				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.				22. DATE SIGNED 8-28-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug. 31, 1967				23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery				23d. LOCATION (City or Town) Taneytown, Maryland				(County) (State)							
24. FUNERAL DIRECTOR John H. Skiles C.O. Fuss & Son				ADDRESS Taneytown, Md.				25a. REC'D. BY REGISTRAR AUG 29 1967				25b. REGISTRAR'S SIGNATURE Charles Judge											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

10894

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10894

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN lb 2 days		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy			d. STREET ADDRESS Route #2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) GERTRUDE			First VIRGINIA	Middle WOODWARD	4. DATE OF DEATH Month AUGUST 31 19 67
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-1888	9. AGE (In years lost birthday) yrs. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Zapp			14. MOTHER'S MAIDEN NAME Ella Virginia Hatfield		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 216-56-8531		
17. INFORMANT Records, Springfield State Hospital			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH years		
(b) DUE TO Cerebral arteriosclerosis			years		
(c) DUE TO Fracture R. hip			8-18-67		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home		
20c. TIME OF INJURY Month, Day, Year Hour o.m. ? p.m. 8-18 1967			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) (County) (State) Rt. 2, Mt. Airy, Carroll Co. Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE W. Glenn Speicher M.D.					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, County) 1585 Main Street, Westminster, Carroll Co. Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/4/1967		
23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive Cemetery			23d. LOCATION (City or Town) (County) (State) Carroll Co. Carroll MD		
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.			ADDRESS		
			25a. REC'D BY REGISTRAR DATE SEP 5 1967		
			25b. REGISTRAR'S SIGNATURE Charles Juge		

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10895

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event within 72 hours after death.

10895		CERTIFICATE OF DEATH						10895				
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>21 days</u>			b. COUNTY <u>Baltimore City</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>			d. STREET ADDRESS <u>1634 Thomas St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <u>FRANK</u>	Middle (NNM)	Last <u>ZUROMSKI</u>	4. DATE OF DEATH Month <u>AUGUST</u> Day <u>9</u> Year <u>1967</u>	Month Year	Doy	Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1897</u>	9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Andrew Zuromski</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Marsky</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unk.</u>			16. SOCIAL SECURITY NO.			17. INFORMANT <u>Records, Springfield State Hospital</u>			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>					INTERVAL BETWEEN ONSET AND DEATH Years?							
DUE TO (b) <u>Luetic aortitis</u>					Years?							
DUE TO (c) <u>General Paresis</u>					Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20o. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-18-67</u> , 19 <u>8-9-67</u> , 19 <u>10:10 PM</u> , to <u>8-9-67</u> , 19 <u>10:10 PM</u> , that (I) (we) last saw the deceased alive on <u>8-9-67</u> , 19 <u>10:10 PM</u> , and that death occurred at <u>8-9-67</u> , 19 <u>10:10 PM</u> , from causes and on the date stated above.											22b. DATE SIGNED <u>8-10-67</u>	
22a. SIGNATURE <u>Dr. Antonius Glahn</u>					22b. DATE SIGNED <u>8-10-67</u>							
22c. PHYSICIAN'S NAME (Type) <u>Antonius Glahn, M. D.</u>					22d. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>							
23o. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-15-67</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>New Freedom</u>			23d. LOCATION (City or Town) (County) (State) <u>Sykesville, Md.</u>					
24. FUNERAL DIRECTOR <u>Harry Haight</u>		ADDRESS <u>Sykesville, Md.</u>			25o. REC'D BY REGISTRAR <u>AUG 17 1967</u>			25b. REGISTRAR'S SIGNATURE <u>george page</u>				

